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ABSTRACT

This guide contains information from the alcoholism literature and from interviews with people in state alcoholism agencies, major professional associations, and public and private service programs. It is designed to help readers plan and develop community alcoholism programs by providing an overview of the many considerations involved in starting and operating a program and by identifying resources that offer more information. The first part of this report concerns planning the program and includes sections on: (1) an overview of alcoholism treatment; (2) foundations for success in planning; (3) needs assessment; (4) program design considerations; and (5) administrative and management issues. Administrative and management issues discussed include organizational structure, staffing and personnel management, recordkeeping and reporting, program evaluation, quality assurance facilities and location, funding and fund raising, and budgeting and cost accounting. The second part of this report discusses needs assessment, outreach, treatment considerations, and administrative issues for serving the special populations of the elderly, youth, the multidisabled, American Indians, Black Americans, Hispanic Americans, Asian/Pacific Americans, and women. The appendices contain lists of further readings, organizations and information resources, and state and territorial alcoholism program directors. (NB)

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A Guide to Planning Alcoholism Treatment Programs

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Alcohol Abuse and Alcoholism

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PREFACE

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) often receives requests for guidance in planning and developing community alcoholism services.

While NIAAA no longer provides direct funding for alcoholism services, we are required to provide technical assistance to States, including public and private entities wishing to improve alcoholism services for their communities. Improving the delivery of quality alcoholism services is a high priority for the Federal Government.

NIAAA believes that this publication—*A Guide to Planning Alcoholism Treatment Programs*—will help you get your own community's alcoholism service program off to a good start. The Guide includes information from the alcoholism literature and from interviews with people in State alcoholism agencies, major professional associations, and public and private service programs.

The Guide is designed (1) to provide an overview of the many considerations involved in starting and operating a program and (2) to identify resources that can offer more indepth information. You're probably interested in helping people who are in particular groups, so extra attention is given to issues related to serving special populations currently underrepresented in alcoholism services programs: elderly, youth, American Indians, black Americans, multidisabled, Asian/Pacific Americans, Hispanic Americans, and women.

The Guide will be especially helpful if you want to develop services that would be supported by public funding or be operated by nonprofit organizations. Because States and counties have their own regulations and procedures, we urge you to start your planning by contacting your county health department and your State agency responsible for alcoholism treatment and prevention services.

State and local government agencies and your local communities are concerned about the quality of care available to those who have problems with excessive alcohol use and abuse. Often, State and local agencies have published their own guidebooks that outline requirements and provide recommendations about steps to follow in developing alcoholism services.

Materials and other resources are available from NIAAA, from major national alcoholism organizations, and from counselor certification and accrediting groups concerned about standards for alcoholism treatment, prevention, and program operations. These materials and resources are listed in Appendix A and Appendix B.

The National Institute on Alcohol Abuse and Alcoholism hopes the Guide will help you—and all of us—in our common effort to make quality alcoholism services available for alcoholic persons and their families throughout the Nation.

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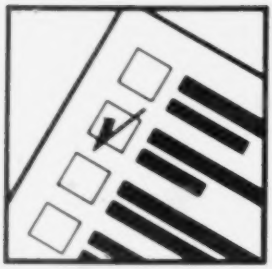

Planning the Program

Alcoholism Treatment: An Overview

"It is evident from the growing understanding of alcoholism as a disease complex that a program of comprehensive community services is essential for the prevention, treatment, and control of the disease. If we have recognized that the disease complex which we call alcoholism is unrelated to morality, that it is not exclusively a result of volition, that it causes physical, emotional, and social problems of great complexity, then we will recognize that community treatment efforts and community treatment goals must necessarily be directed to all of the aspects of the condition as they are to any other disease complex."

This philosophy, stated in one of the first documents[1] issued by the National Institute on Alcohol Abuse and Alcoholism following establishment of the agency in 1971, has been reflected to a large degree in the development of over 4,500 alcoholism treatment services during the past decade. In the early 1970s, alcoholism treatment was not widely available, and what was available was often provided outside the mainstream of the health care services.

In America's early years, the alcoholic was often considered immoral or a criminal, and was thrown into jail or hospitalized where only custodial care was given. A key event in the evolution of treatment services for the alcoholic was the founding in 1935 of Alcoholics Anonymous (AA). This voluntary self-help organization provided support to alcoholics seeking to become and remain abstinent. In addition, it brought to the public's attention the realization that alcoholics could recover and live productive lives. After World War II, there was a dramatic rise in the development of the volunteer movement in the alcoholism field, and a growing number of State governments also initiated efforts to aid alcoholics. Perhaps the greatest impetus to the growth of treatment services occurred in the 1970s when the Federal Government, through the founding of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), provided the financial stimulus for the development of more than 500 community alcohol abuse and alcoholism service programs.

The financial support provided by the NIAAA in developing and testing treatment approaches and in encouraging research into the causes and consequences of alcohol abuse and alcoholism greatly helped to move the field forward. Much knowledge has now been accumulated about alcoholism treatment, including special approaches designed to meet the unique needs of a variety of special

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[1] National Institute on Alcohol Abuse and Alcoholism. *Developing Community Services for Alcoholics: Some Beginning Principles.* Rockville, MD: NIAAA, 1971.

population groups that traditionally have been underrepresented in alcoholism treatment programs.

Alcoholism treatment has moved into the mainstream of the Nation's health care services system. Programs in a wide range of settings are now eligible for health insurance and other third-party support, and health and social services workers are increasingly aware that alcoholism is a treatable disease. The success of early intervention and the growth of occupational alcoholism programs have contributed to the growing public awareness that recovery from alcoholism is possible and that help is available from a variety of sources.

TREATMENT SCENE TODAY

The rapid expansion of alcoholism treatment programs that characterized the 1970s is no longer the case today. A relatively large number of treatment and related services were established during the 1970s, but the rate of development of new programs in the 1980s has slowed. The rate of growth of alcoholism treatment programs is greater today in the private sector than in the public sector; however, the great majority of treatment programs continue to be public ones.

The 1980s have also seen a major change in the source of funds for alcoholism treatment programs. In 1981 President Reagan signed into law the Omnibus Budget Reconciliation Act (P.L. 97-35), which consolidated a number of specific grant programs administered at the Federal level into several broad purpose block grants to the States. Therefore, the Alcohol and Drug Abuse and Mental Health Services block grant funds are provided directly to the States, where decisions about alcoholism treatment program funding are made. Grants are no longer available from the NIAAA for support of treatment services.

Significant increases in private and public health insurance as sources of funding for treatment programs have occurred in the 1980s. Early intervention, particularly in the workplace, has been recognized to be effective, and occupational alcoholism programs have continued to grow. They are now providing a significant source of referrals to the expanding number of private sector and publicly operated programs.

At the same time, a great deal of knowledge has been acquired by NIAAA and other sources that has contributed to the refinement of treatment programming and the integration of alcoholism treatment into community health care services. "Treatment of alcoholism has come of age," declares the *Fifth Special Report to the U.S. Congress on Alcohol and Health,* issued by NIAAA at the end

of 1983 (see Appendix A for ordering information). "Once largely confined to dedicated members of groups like Alcoholics Anonymous and a few committed professionals, treatment efforts in recent years have grown almost exponentially. Treating alcoholics is now respectable—and training for physicians and others to treat the alcohol-dependent person reflects this new-found status," the report states.

"There is an increased willingness to subject therapeutic efforts to research scrutiny—to determine what works best with whom and under what circumstances. Innovative employee assistance programs are now challenging the traditional belief that treatment must be completely voluntary to be successful. The fact that treating alcoholism within the framework of health insurance plans is cost effective has now been proved repeatedly. There is no question that this leads to lower long-term health costs to the individual and the plan. While a hospital was once thought to be the only suitable setting for detoxifying alcoholics, other settings may be equally effective—and much more cost effective. Alternative treatment models employing certified alcoholism counselors have had demonstrated success."

Research and experience have confirmed the concept expressed by NIAAA in 1971 that alcoholism is a disease complex requiring multiple treatment approaches and a coordinated, community-wide network of services. While many questions remain to be answered, the broad consensus is that there is no single "best" way to rehabilitate alcoholics, and that efforts to provide treatment must address not just the drinking behavior but all the physiological, social, psychological, and environmental factors that come into play in the development of alcohol problems and are crucial to long-term recovery.

Alcoholism treatment is provided in a variety of settings by varied combinations of professionals and paraprofessionals. NIAAA has identified and defined more than a dozen settings in which alcoholism services are delivered, as well as eight categories of staff employed in such programs.[2] The type of care may include inpatient, residential, emergency, intermediate, or outpatient.

Settings and types of care. Table 1 illustrates the diversity of the settings and care offered to alcoholics in the United States today. As is indicated on the chart, certain settings offer only specialized types of care, while others offer more comprehensive care. Because the care an alcoholic may need will vary on the basis of individual circumstances, it is important to reiterate the need for a coordinated, community-based approach. Ideally, the full continuum of care from

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[2] Bast, R.J. *Classification of Alcoholism Treatment Settings.* Rockville, MD: NIAAA, 1983.

Table 1. Characteristics of alcoholism treatment facilities

SOURCE: R.J. Best. Classification of Alcoholism Treatment Settings. Rockville, Maryland, NIAAA, 1983, p. 14.

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emergency services to outpatient counseling should be accessible to any alcoholic no matter what the specific nature of the program entered. Patient access requires cooperation and coordination among service providers.

The Classification of Alcoholism Treatment Settings includes neither individual service providers, such as individual physicians, nor does it include Alcoholics Anonymous, primarily because this group does not view itself as a treatment program. However, it is important to recognize that individual providers and this self-help network play vital roles as an adjunct[2] to formalized treatment programs.

According to the most recent national statistics,[3] there are more than 4,000 individual units in the United States providing alcoholism treatment services; in a 1982 survey, a total of 4,233 units responded, representing 90 percent of all known alcoholism treatment units. However, this number does not necessarily include all private providers. Of those providing information to the survey, 64 percent served alcoholics only, while the remainder served both alcoholics and other drug abusers.

Descriptive data indicates the great majority of programs provided less than 24-hour care and that most clients (78 percent) were receiving outpatient care in a variety of settings. Of all treatment units responding to the survey, 48 percent were freestanding alcoholism treatment units, 21 percent were housed in community mental health centers, and 12 percent were part of general hospitals (including Veterans' Administration hospitals).

The majority (68 percent) were nonprofit organizations, with most of the remainder being State or local government funded and operated. Only 7 percent of the units responding to the survey were for-profit operations. While the majority of service providers are, at least in part, publicly funded, the private sector is growing much more rapidly than is the public sector.

Services. Treatment services offered by the reporting programs were diverse and include individual therapy and/or counseling, group therapy and/or counseling, family therapy and/or counseling, referral and other information, and screening. The specific treatment approaches were not identified in the survey. However, according to a review by Diesenhaus,[4] three major classes of alcoholism treatment models are in widespread use—physiological, psychological, and sociocultural.

"Physiological treatment strategies focus on the person as the unit of treatment and use pharmacotherapy to produce change in the alcoholic. Psychological treatment strategies also focus on the person and use psychotherapy or behavior therapy to help the alco-

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[3] *National Institute on Alcohol Abuse and Alcoholism. National Drug and Alcoholism Treatment Utilization Survey 1982 Comprehensive Report.* Rockville, MD: NIAAA, 1983.

[4] Diesenhaus, H. Current trends in treatment programming; In: NIAAA. *Prevention, Intervention and Treatment: Concerns and Models. Alcohol and Health Monograph No. 3. Rockville, MD: NIAAA, 1982.*

holic change behaviors. Sociocultural treatment strategies focus on both the person and his or her social and physical environment as the units of treatment and use a variety of techniques, including environmental structuring, to provide new social relationships for the alcoholic," Diesenhaus explains. To some extent, the setting will dictate the type of care and the service model. Hospital detoxification, for example, deals with physiological issues. However, most programs—inpatient, residential, and outpatient—include a combination of approaches.

Staffing. The types of staff who provide services are determined by the setting and type of care offered. Obviously, emergency care in hospital settings requires medical staff. However, according to the NDATUS survey, alcoholism counselors were most frequently the major providers of direct care in most settings. Other providers include physicians and psychiatrists, social workers, nurses, and psychologists. In addition to the paid staff, volunteers represent a significant portion of those who provide alcoholism treatment services. According to the NDATUS survey, about 14.8 percent of the staff in treatment units were volunteers, a full-time equivalent of about 8 percent of the total staff.

CONTINUING NEED FOR TREATMENT PROGRAMS

The fact that the settings, services, and types of care available to alcoholics vary widely does not imply that all conceivable needs for alcoholism treatment are being met. Although a great deal of progress has been made, many gaps in knowledge and service remain.

The number of alcoholics receiving treatment is still far below the number of Americans estimated to have alcohol-related problems requiring treatment. Diesenhaus observes that "despite the increase in the availability of treatment and the decrease in the stigma, it appears that formal treatment is still not received by a majority of alcoholics identified in community surveys."

Existing as well as new programs should consider developing services that meet the special needs of underserved groups. According to the *Fifth Special Report to the U.S. Congress on Alcohol and Health,* "The problem of developing programs suited to special populations such as women, ethnic minorities, and the elderly has become important. As this and earlier reports indicate, groups such as American Indians have much higher rates of illness and death from alcohol-related illness than does the general population. It is critical that treatment programs be designed to overcome cultural, economic, and other barriers that deter some groups from seeking treatment."

Indeed, it is important that program planners carefully consider the needs, not just of special populations groups, but of the entire community in the context of the existing community services. There are constraints on resources, particularly in the public sector; however, the need to develop treatment services for alcoholics and

their families remains a pressing one. As is observed in the *Fifth Special Report to the U.S. Congress on Alcohol and Health* report, "Treatment offers many opportunities for increased innovation. Alcohol problems have plagued most societies throughout history. But never before have we had as much basic knowledge as we now possess, with the promise of still greater understanding to come. Developing a new alcoholism treatment program requires careful and thorough planning, taking into consideration the many aspects of program development and operation necessary to a viable, effective program. It is a complex undertaking. It requires commitment, hard work, time, and the investment of money, as well as skills in treatment and in administration. Planning is a key step."

Planning: Foundation for Success

Chances are, if you are thinking seriously of starting an alcoholism treatment program or expanding an existing one, you have a pretty good idea of the needs that exist, what services you want to offer, in what setting, and for whom. So why should you invest the time, energy, and money necessary to develop a detailed plan?

There are some very good reasons. First, taking the time to thoroughly consider all of the aspects of setting up and running a program can contribute greatly to your chances of success. Planning is the foundation on which your program will rest. It is critical before you open the doors to have in place a very solid plan that covers administrative and personnel procedures, accounting and business systems, followup and evaluation procedures, and all the many routine aspects of startup and day-to-day program operations. Careful attention to the business aspects of program operation and development of a very conservative fiscal projection is essential. More programs have failed because of poor business management than for any other reason. Working through the startup financing costs and realistically projecting the operating costs help ensure that your new program won't be caught short by unexpected expenses. And thoroughly analyzing the needs of the community, how the new program will fit in with existing service delivery systems, and how most effectively to reach and treat potential clients ensures that the program will generate the projected caseload.

Another pragmatic reason for planning is that in many areas of the country your State alcoholism agency or county governing body requires that you justify the need for your service in order to be eligible for funding. Even if you are not seeking public funding or reimbursement for services from public sources such as medicaid, you will in all likelihood need to provide private funding sources with evidence that your program will meet a need, that the services you will offer will be used, and that you will operate according to sound management practices. In addition, third-party reimbursement from health insurers is generally based on your program meeting a set of standards that require a sound planning base.

Finally, a formal planning process allows you to involve those in your community whose support will be important, as well as members of the groups you are seeking to serve. Thus, your program planning can include the valuable ideas of those who will constitute your referral sources and those who can express the needs of your target groups.

WHERE TO BEGIN

How should you proceed in developing a program plan? The first step should be to visit your State Alcoholism Authority, (see Appendix C for a list of State Alcoholism Authorities), who may refer you to one or more other State agencies, a regional health planning body, or your county health department. You will be able to find out such information as (1) whether your program is governed by licensure, certification, or other requirements, (2) what guidelines are available to assist you in the planning process, (3) what the regulations are regarding eligibility for health insurance and public fund reimbursement for your program, and (4) if you are seeking public funding, what budget processes apply to you.

In a review of alcoholism services, Akins and Williams [5] noted that health planning services in most areas have traditionally been a county government responsibility. The State will also be involved in some aspects of program development or in monitoring programs once they are in operation. The reviewers observe that "most States conduct periodic monitoring and program audits as conditions for receipt of funds appropriated by the State." In practice, monitoring is more likely to take the form of technical assistance to program staff in the essential aspects of program operation such as recordkeeping, financial management, treatment techniques, and evaluation. Monitoring may also involve judging program compliance with State standards for operation.

Many States monitor programs in conjunction with the issuance of State licenses for operation. Often the issuing agency is not the State alcoholism agency, but rather a program-licensing office in another agency of government. Local units of government also issue licenses. Licensing criteria require, at a minimum, adherence to standards for both services and facilities. Licensing is a critical function for program funding, not only to qualify for State funds, but also to receive reimbursement from public and private insurers. Assuring and improving the credentials of persons who provide alcoholism services is another area of growing importance for State and local responsibilities in quality assurance.

If your program will serve a significant American Indian population, you should call the area office of the Indian Health Service. This Federal agency currently funds alcoholism treatment programs serving a number of Indian tribes and urban American Indian organizations. No funds are available for new programs, except for those tribes that have identified a need for

[5] Akins, C., and Williams, D. State and local programs on alcoholism. In: NIAAA. *Prevention, Intervention and Treatment: Concerns and Models. Alcohol and Health Monograph No. 3.* Rockville, MD: NIAAA, 1982.

alcoholism treatment services in their Tribal Health Plan but do not have access to such services. The area IHS office will be able to provide you some advice and technical assistance.

The specific rules and regulations applicable to the development of alcoholism treatment programs vary from State to State and, in some areas, from county to county. In some cases, the process can be quite lengthy, while in other instances the startup requirements are minimal. Remember that virtually all States have some sort of program standards document that sets forth minimum criteria for program operation in order to qualify for reimbursement from public funds.

In a number of States you must comply with a health planning process in which you must justify a community need and describe the services that your proposed program will offer. This requirement may apply to all new programs or just to inpatient programs. Some States require some or all types of programs to be licensed. In other States, there is a certification process that, again, may apply only to some settings.

For example,[6] in Mississippi, inpatient programs have to go through the Certificate of Need (CON) process. In this State, the process is administered by the Health Care Commission. For those seeking to offer outpatient services only, a CON is not required. However, if such programs want to be eligible for reimbursement from public funds, they must apply to the State alcoholism agency for certification, demonstrating compliance with program standards. If the program treats both drug addicts and alcoholics, additional regulations governing methadone maintenance apply.

In California, alcoholism treatment programs not seeking public funds can start without going through any governmental approval process, as long as they comply with zoning, building code, and other safety requirements. The counties are responsible for approval of service delivery for outpatient programs, but inpatient facilities must be licensed by the State, Department of Social Services. The State is not involved in the planning and startup process for most types of programs, but does certify programs that want to receive reimbursement from public sources once they are in operation.

In contrast, New York's Division of Alcoholism and Alcohol Abuse provides considerable assistance to those planning programs. Such assistance includes a program development manual that details how to conduct a needs assessment, a discussion of program design considerations, an explanation of the Certificate of Need review process, and lists of various resources for program development. Those seeking to start a new program in New York must begin at the county level by getting their proposed program included in the county's plan. This requirement applies to public and private programs. Once in a county plan, the proposal is sent to the

[6] The examples of State regulations given here are intended to illustrate the diversity in regulations and approval requirements. The specific information about requirements and procedures was accurate as of June 1, 1984, but can be expected to have changed over time.

State for review and the Certificate of Need process must be completed. Those seeking public funds must then proceed through the budget review and approval process. All new programs, or programs planning substantial expansion, must go through some formalized planning and approval process at both the county and State levels.

The best place to start unraveling the regulations specific to your planned program is with your State's alcoholism agency. Not only can this agency advise you of what regulations may apply and what agency in the State or county you must work with, but also they will know of special conditions affecting new program approvals. For instance, some States have temporarily deferred approval of new beds for alcoholism treatment because of a surge in private inpatient programs. Previously such programs were virtually free of regulation in many States, although they had to comply with national hospital accreditation standards.

PROGRAM STANDARDS

State and county regulations are not the only consideration for alcoholism treatment programs. If you are interested in making sure that your program is eligible for third-party reimbursement, most insurers consider compliance with the Joint Commission on Accreditation of Hospitals (JCAH) *Consolidated Standards* as evidence of an acceptable operation (see Appendix A for ordering information). Accreditation by JCAH is based on compliance with standards intended to reflect excellence in program performance, determined by peer review. Many States will waive licensure requirements if a program obtains JCAH accreditation.

National program standards have also been developed by NIAAA. The *Program Standards for Alcoholism Treatment* document identifies specific program characteristics and activities thought to be necessary for effective operation (see Appendix A for ordering information). These standards were developed by clinicians and program administrators from the alcoholism field and are applicable to programs in any setting.

While this planning guide highlights the basic elements necessary to acceptable program operation, a great deal of detail is available in the manuals listed in Appendix A.

The remainder of this guide discusses the process involved in program planning, highlighting the key elements that must be considered. The overall goal of the planning process is to identify and document the need on which the program is based, to clearly state the philosophy and rationale of the therapeutic services offered, and to develop the administrative elements that guarantee sound operation.

It is important to note that research into the effectiveness of treatment programs is not yet extensive. Thus, the advice and suggestions in this guide rely mainly on the observations of those who have experience in operating treatment programs. You should be aware that much of the information presented is based on clinical observation rather than on research. However, every attempt has been made to solicit the thinking of a number of experienced alcoholism treatment specialists to ensure that the suggestions included represent the best knowledge available at this time.

Needs Assessment

The logical place to begin in developing a program plan is to gather data on the nature and extent of the people and families with alcohol problems in your community, to identify existing services and the unmet needs for services, and to describe the characteristics of the groups to which services need to be made available. Depending on the resources available to you, such data can consist of rather elaborate large-scale survey results, or can simply consist of local data gathered from key local agencies likely to be affected by alcoholism problems. A review of the available national statistics can be included.

GATHERING THE DATA

While the national statistics on the rate of occurrence (incidence) of alcoholism can be extrapolated to the local level, program specialists agree that it is vitally important to gather local data. Five approaches to gathering needs assessment data were presented in a manual for health planners published in 1980, *Health Planning Technical Assistance Manual for Alcohol and Drug Abuse Agencies* (see Appendix A for ordering information); the advantages and disadvantages are summarized in Table 2. In planning a community treatment program, you may want to combine several of these approaches.

According to NIAAA's program standards, you should collect information on the characteristics and distribution of the population to be served by the program in order to plan services to meet the needs of the community. This will include information on the populations and the community to be served, such as the following:

- Geographic distribution of the population
- Age, sex, and socioeconomic characteristics of the population
- Racial and ethnic characteristics
- Employment and unemployment patterns
- Educational levels
- Household compositions
- Transient groups within the population
- Unique cultural features of the population
- Future demographic trends within the population
- Patterns of alcohol consumption.

Much of this information is available from existing resources in your county or State—such as the county planning board, the health systems agency, and health planning commission.

TABLE 2. Summary of Selected Needs Assessment Approaches

	DEFINITION	ADVANTAGES	DISADVANTAGES
Community Survey Approach	Formal systematic survey of defined populations in specified geographic areas to gather factual information on residents' health, social well-being and pattern of service utilization.	• Can provide up-to-date data and perceptions on needs. • Has considerable design flexibility. • Provides opportunity to gather data on those individuals who may have unmet needs.	• Is expensive relative to other methods of needs assessment. • Survey sample may not be accurately representative of planning area population. • Reluctance of respondents to supply data. • Reliance on respondents' memory of health care utilization and problems.
Community Forum Approach	Solicitation of opinions, anecdotes, experiences, and impressions from community residents through a series of public meetings.	• Relatively easy to arrange. • Inexpensive compared to other needs assessment methods. • Can serve as a catalyst to initiate activities to improve health systems.	• Impossible to assure representation of all views. • Can potentially deteriorate into public grievance sessions rather than reasoned needs identification.
Key Informant Approach	Interviews with public officials, administrators and program personnel in health and welfare organizations, health care providers, consumers, etc.	• Minimal expenditure of time and resources required. • Focuses needs assessment effort on precise issues. • May establish communication lines among human services agencies represented.	• May incorporate the professional biases of the key informants. • Not representative of the community. • Reliability and validity of findings are debatable issues.
Rates Under Treatment Approach	Extrapolation of an estimate of community needs by enumerating aggregate data on services utilization and descriptive data on the population utilizing the services.	• Data needed are usually available and relatively inexpensive to secure and analyze.	• Utilization figures are likely to understate or overstate actual need. • Its simple formula does not explicitly permit the identification of probable ranges of need.
Social Indicators Approach	Application of the principle that certain sociodemographic variables correlated with needs and, thus, can be used as indicators or surrogates of need.	• Availability and low cost of data to users. • Considerable design flexibility. • Indicators can be analyzed separately or combined into a single need index.	• Causal relationships between social indicators and alcohol/drug abuses are not very well known.

SOURCE: National Institute of Mental Health. *A Manual on State Mental Health Planning*. Washington, DC: Department of Health, Education, and Welfare, Pub. No. (ADM) 77-473, 1977, pp. 67-81; cited in National Institute on Alcohol Abuse and Alcoholism. *Health Planning Technical Assistance Manual for Alcohol and Drug Abuse Agencies*. Rockville, Maryland, 1980, p. 28.

Beyond general descriptive data, other information about the service needs of the community is useful. By extrapolating from national data available from NIAAA, the National Highway Traffic Safety Administration, and other sources, information on the extent and nature of alcoholism for the target population can be established. Another useful approach is to gather local data obtained from agencies most affected by alcoholism—social services, hospitals, criminal justice, vocational rehabilitation, education, highways and police, mental health, and fire and safety services. Because alcoholism is not always identified by these agencies, it may be necessary to do some probing and make assumptions based on national data regarding the alcohol problems in these areas.

Some data reflect directly the incidence of alcoholism problems (e.g., rate of deaths from cirrhosis). However, it is likely that the full extent of alcoholism and alcohol-related problems will not be reported by all the agencies you contact nor will it be reflected in the statistics they have available. Thus, it is useful to look at national data (see Appendix B for sources of such data), and use them to develop an estimate of the alcoholism incidence in your community. For instance, according to national statistics, alcohol is involved in 50 percent of all traffic accidents; however, many States and counties report alcohol involvement only in cases where fatalities occur. So you may find that alcohol involvement in traffic accidents in your locality is underreported. Likewise, you may want to review national estimates of alcoholism incidence among special population groups. If the existing local treatment services report a low rate of alcohol problems among women, for example, this is likely to point up a need for services that can engage this group who are likely to remain "hidden alcoholics."

You will need to describe existing community resources—programs, sites, client characteristics, referrals, and other aspects of the service delivery system relevant to alcoholism treatment.

You should combine your data and narrative into a clear statement of (1) the demographic and geographic features of the community, (2) the nature of alcoholism problems, (3) the population to be served, (4) the extent of alcohol problems, (5) effects on the community, (6) resources now available to meet the problems, and (7) the needs the proposed program will meet.

You should also obtain information about the priorities and plans of local, State, and regional health planning agencies. Generally, a long-range plan is available from State health systems agencies and health planning commissions, the State alcoholism agency, and local planning agencies. There are general county, State, and regional health plans available,

and it is important that your proposed program reflects or fits in with established priorities.

NIAAA's Alcohol Epidemiology Data Systems (AEDS) project has developed a manual outlining procedures for assessing alcoholism treatment needs that takes into consideration both the demand for services (based on current utilization of treatment programs) and indicators of unmet needs (such as DWI statistics and morbidity and mortality data). According to the AEDS manual, "Currently in the United States, most treatment planning is based solely on previous treatment utilization patterns that are considered to be indicators of the "demand" for treatment resources as expressed by persons presenting themselves to treatment.[7] The AEDS method addresses all of these criteria, providing planners with a formula they can follow to determine community and regional treatment needs. The material is geared to State or regional planners, but offers valuable background information for the program-level planner, as well. (A condensed version of the manual will be published in NIAAA's quarterly magazine *Alcohol Health and Research World;* see Appendix A for ordering information.). "To best determine a match between populations and services, assessment methods should be (1) problem specific and related to a particular population and a given facility's service; (2) community specific and not extrapolated from data in other areas and circumstances; and (3) based on data relevant to the process by which individuals come into treatment or rehabilitation unit of the particular facility."

INVOLVING KEY PEOPLE: THE ADVISORY COMMITTEE

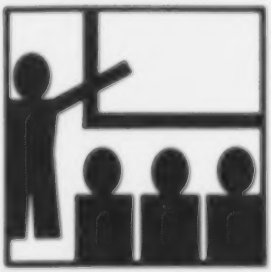
The needs assessment process involves more than gathering information about the alcoholism treatment needs of the community in a vacuum. Any new program must get support from community leaders. It is vital to involve influential community members from the start, as members of an advisory committee, and to keep them involved once the program is in operation.

Who should be on an advisory committee? According to a manual developed by the National Association of Counties (NACO), many organizations from the Jaycees to the Salvation Army have already recognized alcoholism in their own group and started prevention programs (see Appendix A for ordering information). Representatives of these groups can provide the nucleus of the advisory committee. You may want to ask members of other organizations, particularly those involved in alcoholism education or treatment or both, to join the advisory committee, such as the Parent-Teacher Association (PTA), Young Men's Christian Association (YMCA), local Council on Alcoholism, the United Way, League of Women Voters, and many religious and minority groups.

It is not always realistic to expect that you will be able to recruit recovering alcoholics to serve on the advisory committee from

[7] Alcohol Epidemiologic Data System. *Procedures for Assesing Alcohol Treatment Needs* (Administrative Document). Rockville, MD: NIAAA, June 1982.

the outset. If the person starting the program is recovering, it is probably more feasible to recruit "consumers" from the outset. However, it is essential that the advisory committee include members of the group the program intends to serve—either AA members not affilitated with the program or "alumni" of the program—once the program is in operation.



The NACO manual provides the following list of groups from which advisory committee members should be chosen and reasons for their inclusion:

- Schools. Alcohol abuse among youth is increasing.
- Business. Early intervention in alcoholism can frequently be accomplished on the job. Business leaders know the problems they encounter with alcoholic employees. They also bring managerial advice and expertise to the advisory committee.
- Religious organizations. They have long been involved with alcoholic members and their families.
- Service organizations. Their valuable field experience and knowledge of available resources contribute directly to the advisory committee.
- Unions. Labor organizations want to provide alternatives for their members who are in trouble with alcohol.
- Health-care providers. Doctors, nurses, and other health-care workers see the results of untreated alcoholism daily.
- Legal professionals. Marital breakdowns, assaults, vagrancy, and many other crimes and problems come to their attention.
- Minority groups. Organizational representatives and other individuals can contribute special knowledge of the problems and needs of their constituents and communities.
- Criminal justice professionals. Law enforcement and judicial personnel see more alcoholics than any other group in the country (except perhaps AA). From arresting public inebriates, mediating family disputes, and judging cases of aggravated assault, they have a clear view of the problems of alcoholism. Their cooperation is vital to the success of any treatment program.
- Reporters and editors from the news media. They have broad knowledge of the needs and concerns of the community. They also have the means to inform citizens of new approaches to treatment.
- Women's groups. They provide valuable contacts with a hard-to-reach population.

REACHING SPECIAL POPULATIONS

An advisory committee can play a particularly important role in helping you to identify the needs of special population groups now underserved by alcoholism treatment services in the community.

It is important to try to identify concentrations of special populations in the community and to determine the extent of alcohol problems among these groups. It is equally important for you to identify special barriers to treatment unique to these groups, so that you design a program that will be accessible and effective. Involving members of minorities and other special populations on the advisory group and arranging to meet with community organizations that represent the interests of particular special populations are good ways to gather such information.

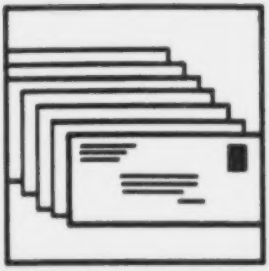
The *Fifth Special Report to the U.S. Congress on Alcohol and Health* notes that in designing programs for special populations, planners must be sensitive to structural- and group-specific barriers that restrict access to facilities. "For example, a survey of 53 California treatment facilities suggested that women alcoholics were less likely to enter programs lacking child care services, professional staff, and aftercare programs," the report notes. "Other barriers to treatment for some groups are language differences and composition of treatment staff. Minority staff members represent only a small proportion of the Nation's alcoholism treatment staff. Yet another barrier may be financial contraints. Women and minorities are overrepresented in publicly funded facilities and underrepresented in private ones. Without programs' sensitivity to the needs of these populations, many individuals may fail to seek treatment until their alcoholism has reached a severe stage of development."

Beyond identifying and overcoming barriers to treatment, you must also consider incorporating into your program culture-specific services. For example, "some facilities seeking to attract Hispanic and American Indian clients are using folk and tribal medicine and nature healing approaches as alternatives or adjuncts to traditional medical and psychiatric treatments," the report notes. "Counselors and other treatment staff members are being matched to the sex and ethnic background of their clients." Culture-specific services and alternative approaches to treatment require program staff well-trained to offer these services and methods. Additional aspects of planning treatment programs for members of specific population groups are presented in a separate section of this document.

ADDITIONAL CONSIDERATIONS

There may not be perceived need in a given community for the type of alcoholism treatment service you want to provide. Particularly in the private sector, part of the initial planning may include a market analysis, seeking to determine whether and how the program's services can be "sold." Many private sector programs have been successful in marketing services to a specific source, such as industry. If such marketing efforts are to succeed, there must be a real need for

the services. This need may not have been perceived by businesses, however; thus, you may want to build on their needs assessment data by going on to conduct a market analysis.



While most public sector and nonprofit programs recognize the need to market their services, through outreach and awareness activities, they have not always identified in a systematic way just what are the most effective ways to reach their target groups. You will need to develop an overview of what might be involved in a comprehensive outreach and marketing analysis. The elements of such an effort might include developing a program image, planning a coordinated strategy using the media, targeting outreach and marketing messages to specific special population groups, and budgeting. Looking at such elements during the planning phase can help to ensure that once your program is under way, you have allowed sufficient resources and you have a carefully conceived plan to make sure those who you want to serve actually take advantage of those services. A detailed discussion of marketing strategies designed to help programs target services to specific groups is provided in *Program Revenue: A Challenge of the Eighties* (see Appendix A for ordering information).

TRANSLATING NEEDS INTO AN ACTION PLAN

Once you have defined the nature and extent of alcoholism problems in your community as accurately as possible, you can develop a program plan that reflects the need. According to the New York State guidelines, for example, this involves consideration of various program options and selection of the most feasible program—that is, a program that has realistic and measurable goals and reflects available resources. The advisory committee should be involved in analyzing the needs assessment data and translating it into a program plan.

Defining what the program will seek to accomplish permits an examination of alternatives—different ways for reaching the objective or goals. In a manual prepared for NIAAA, *Management Program for Alcoholism Services Projects* (see Appendix A for ordering information), five questions that must be answered in developing program objectives are identified as follows:

- What is the impact your program is expected to have on clients?
- What is the outcome or result you want to obtain?
- Who is your target population? If there is more than one, will there be differing objectives?
- What is the geographical area you will serve?
- When will your program accomplish its objectives?

Most programs set forth the goal of reducing alcoholism and alcohol problems among the population they serve, as measured by abstinence from alcohol and improved social functioning among their clients. This broad goal must be translated into specific objectives if program planning is to be realistic. Thus, you might set forth as an objective: "To provide individual counseling services on an outpatient basis to 200 clients during the first year of operation." You should seek to base estimated caseloads on the needs assessment data, and identify marketing strategies as well as the types of outreach and referral arrangements needed to ensure that these clients "find" your program. The types of treatment and other services you feel are necessary to meet the needs of the target population should also be identified, with expected timetables and numbers of clients to be served determined as specifically as possible. Objectives must also reflect the ethnic and cultural characteristics of the target populations as well as special needs unique to a particular subgroup. For instance, if there are large numbers of elderly citizens living in the area you plan to serve, you might set forth the following as an objective: "To conduct a half-day awareness/outreach session in each elderly housing project and senior citizens center within the first 6 months of operation."

Once the program's philosophy and objectives are clearly stated, you can begin to examine alternative approaches to providing the needed services. In most cases, the alternatives available will be subject to certain constraints—such as legal statutes, regulations, and guidelines from funding sources and umbrella organizations. Your objectives will lead you to consider how your program can most effectively fit into the existing service delivery system, what setting and type of services will be most accessible to and appropriate for the target population, and what treatment approaches and type of staffing will be necessary to support the objectives.

It may be that there will not be adequate resources to support the program you wish to develop. If so, you might seek additional resources, scale down the program objectives, consider a phased program development plan, or seek ways to develop more cooperative relationships with another service provider. It is at this next point in the planning process that you should become very specific and realistic about what it will take to implement a program that will meet the objectives you have set.

Program Design Considerations

The primary goal of any alcoholism program is to provide services to clients. Thus, the configuration of your treatment program will be a major concern. What services will you provide, and in what setting?

Ideally, the full range of treatment services and settings should be available to all alcoholics in all communities. Thus, it is important to consider carefully existing programs in designing any new ones to avoid duplication and ensure that the new program complements and is complemented by existing ones.

As was stated in the Overview, there is no single "best" treatment approach or setting. However, research on the effectiveness of alcoholism treatment is beginning to show how to match clients to the most appropriate treatment setting and service. It is generally recognized that alcoholism is not a unitary disease. Accordingly, the emerging model for treatment emphasizes the need for accurate diagnosis and development of an individualized treatment plan that includes improving the clients' health, psychosocial functioning, and coping skills, as well as the cessation of drinking.

Often, alcoholic clients will require treatment in a succession of settings, moving from detoxification to residential care to outpatient care. Thus, programs are encouraged to offer all clients access to the full continuum of care. It is seldom feasible for a program to directly provide every service that might be needed by the target population; it is important, therefore, that to the extent possible, access to a broad range of services be provided through referrals.

No matter what the setting, you should consider how your program will provide access to the major service elements discussed below.

OUTREACH AND COMMUNITY EDUCATION

How can a program locate and contact people in need of treatment? One way is to establish referral agreements with other agencies. However, many clients come to alcoholism treatment programs as self-referrals or because of pressure from family members, friends, and employers. It is important, then, for a program to maintain an active and aggressive outreach program. Such a program should inform the community at large of the services it offers and make contact with those in a position to refer alcoholics from special populations most likely to have a higher than average rate of

alcohol problems or to be generally underserved by alcoholism treatment programs. The advisory committee members can often provide a new program with entree to such individuals and organizations.

Many programs find it useful to contribute to efforts to educate the community about alcoholism. Often there is a voluntary group or alcoholism council that operates public education programs. It is important that you not duplicate such activities, but rather support or complement them. Community awareness activities might focus on the value of early intervention, stressing that alcoholism is a treatable disease and that the recovery rate is significantly greater when people enter treatment before their drinking has reached an advanced problem stage.

This might be followed by (1) visits to local employers to discuss ways they can make employee referrals to treatment, (2) appearances at youth groups, civic groups, and women's clubs to talk about the benefits of family intervention and family support services the program may offer, (3) and discussions with "gatekeepers" (such as ministers) who are in a position to identify early signs of problem drinking and make referrals.

Outreach efforts may take the form of consultation to other agencies or organizations; you may want to plan to provide seminars for health, criminal justice, or social service professionals on how to administer alcoholism screening instruments to clients. Such consultation supports the concept of early intervention and also provides for more comprehensive identification efforts. All too often, alcoholics are not referred to treatment because helping professionals are not aware of the symptoms of the disease.

INTAKE AND ASSESSMENT

Your program will need to develop an intake process, to include written criteria for admission, procedures to be followed during the initial visit, and the assessment of client needs. The intake process should ensure that all potential clients are treated in a systematic, well-defined manner.

Specific written criteria for admission are necessary; if your program contains multiple treatment components, admission criteria for each component should be identified. These admission criteria will be based on the resources of your program to treat clients, and should identify financial requirements necessary to complete the program. Criteria may include provisions regarding involuntary admissions, repeat admissions of clients who fail to maintain sobriety, nondiscrimination based on race, sex, age, national origin, and disability, ability of the individual to assume full responsibility for his or her own decisions and actions, and so forth. Denial of admission might be based on these criteria: the program is operating at capacity, none of the treatment services offered is appropriate to the particular applicant, preference is given to clients unable to pay, preference is given to clients living within the immediate neighborhood of

the program, or the client's family or living situation intrudes into the treatment process in a counterproductive way. Referral resources for individuals who are not eligible for services should be identified.

In order to develop an appropriate treatment plan, there must be a systematic determination of any emergency medical needs, as well as an assessment—using interviews and screening instruments—of the client's drinking history, psychosocial history, and medical history. Some programs involve the entire family in the assessment, developing a family history of alcohol and other problems and exploring family relationships and strengths.

According to the *Program Standards for Alcoholism Treatment* manual, information to be gathered in the intake interview includes basic demographic data and referral data. Beyond this, most programs will also be interested in the following areas:

- Presenting problem
- Alcohol-drug use and problems history
- Family/interpersonal history
- Education/employment/vocation/history
- Medical history
- Legal history and current status
- Psychosocial history
- Psychosexual history
- History of previous treatment.

In addition to collecting information about the client, a potential client should receive information about your program. This orientation typically should include information on program goals and rules governing behavior during treatment, services available and hours of operation, costs and fees and the responsibility of the client for payment, and information on clients' rights. A thorough orientation will ensure that the client's consent to treatment is an informed process.

The assessment information is often evaluated by a team, so that underlying psychiatric and medical problems do not go undetected. The criteria that programs use for assigning clients to treatment vary widely; however, a widely accepted set of criteria for classifying alcoholic patients along a number of dimensions is provided in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III) developed by the American Psychiatric Association. As research continues into how best to match client characteristics and treatment modalities, such diagnostic classification will most likely take on greater importance.

The assessment process should also include sensitivity to the special characteristics of certain special populations groups. While the broad categories listed previously are designed to elicit all essential information, it is important for intake counselors to be aware that certain groups may be reluctant to divulge pertinent infor-

mation if not specifically questioned. For example, an elderly client may be taking an over-the-counter medication that aggravates the effects of alcohol consumption, but might not mention this because it is not a prescription drug. The Hispanic client may take offense at questions about family and interpersonal relationships because of strong cultural proscriptions against sharing family secrets; counselors will need to be sensitive to these issues.

INDIVIDUALIZED TREATMENT PLAN

It is important that an individualized treatment plan be developed for each client, based on the assessment of his or her needs. This plan should identify specific problems to be resolved during treatment, outcome goals, treatment methods to be used to achieve the outcomes, and provisions for periodic reviews and updating. Client involvement in the development of the plan is desirable.

Each treatment component your program will offer should be identified and clearly explained in terms potential clients can understand. Except in cases where the focus of the program is limited to a specific function, you should develop a system and procedures for providing clients with access to the full continuum of care, either directly or through referral as needed. This includes access to emergency medical services, medical or social detoxification services, residential care, outpatient care, and aftercare services.

Beyond the development of an initial plan, there should also be a procedure for periodic review of client progress, as well as for tracking clients who are receiving services from other agencies. As the treatment progresses, a formal discharge plan should be developed by the client and his or her primary counselor, specifying the goals that must be obtained before discharge and setting forth an aftercare plan. It is critically important that aftercare planning take place while the client is still in treatment, in order to ensure that the transition back to the community can be made smoothly. Generally, the aftercare plan will include followup visits to your treatment program and participation in an AA group; specialized services may also be offered by other agencies.

TREATMENT SERVICES

Most alcoholism treatment programs combine individual and group therapy sessions and include access to support groups such as Alcoholics Anonymous. No single treatment approach has been shown to be effective with all alcoholic clients, and a relatively broad range of treatment modalities are in use. "Several diverse treatments are often delivered within the context of alcoholism services, depending on the resources and needs of clients, as well as the specific training or orientation of the staff," according to the *Fifth Special Report to the U.S. Congress on Alcohol and Health.*

"In many cases, a combination of therapeutic interventions is provided to all clients, under the assumption that multiple treatments stand a good chance of meeting at least some of each client's needs."

The report notes, however, that "in recent years, psychotherapeutic approaches have given way to, or have been combined with, behaviorally oriented treatment in many settings." Group therapy is frequently included in alcoholism treatment in virtually all settings that provide long-term care, and often focuses on social skills training. However, individual therapy should always be available for those who need it to develop trust early in the treatment process. This is especially true for certain segments of the population, such as women. Pharmacological agents such as disulfiram (Antabuse) are also widely used in combination with individual and group therapy sessions as a reinforcing factor in maintaining abstinence.

Increasingly, alcoholism treatment programs are taking a holistic view of client needs and are providing access to a broad range of adjunct therapies and support services, sometimes through referrals and sometimes on site. These include "creative" therapy (art, dance, music), recreational therapy, vocational rehabilitation, occupational therapy, and a wide range of social service assistance—ranging from money management to housing. This reflects the importance of preparing clients to return to their home environment and develop a new way of life; thus, there is an emphasis on developing new skills and abilities and on providing aftercare support to prevent the client from returning to an alcoholic lifestyle. Improved social and emotional functioning are necessary to an alcoholic client's recovery.

In line with this view, many experts have recommended that family therapy be provided for alcoholic clients with intact families, traditional and otherwise. While not all programs have the resources or staff training to provide such services, the impact of alcoholism on other family members and the concept that alcoholism is a "family disease" argue for the inclusion of such services.

Other services such as transportation, food service at the program site, or child care may also be required. You must consider what nontherapeutic elements of service are necessary to ensure that clients are able to take advantage of your treatment program.

REFERRALS

If clients are to be referred from your alcoholism treatment program to another agency, or to another component of the same program, it is important for you to consider what procedures will be used, what documentation is required, and what followup by program staff will be required. You must consider the staffing implications of referring clients to other community agencies for support services; staff time will have to be devoted to developing and maintaining referral linkages as well as to follow up on individual clients with staff at other agencies.

Your needs assessment will include the identification of agencies offering services that program clients may require. However, some further exploration will be necessary to determine how willing such agencies are to accept referrals, their capacity and eligibility requirements, and the expectations of the referring agency. The criteria your program will use to make referrals and the process that will be followed to ensure that clients are being served appropriately must also be considered. It should also be recognized that developing referral arrangements is an ongoing process; your program plan should include ongoing contact between your program and the referral agencies, as well as data collection and analysis to track client use of specific referral resources.

Many of the agencies and organizations to which your program refers clients will also serve as a source of referrals to your program. It is important that you identify those likely to provide significant numbers of referrals and factor into your outreach plan an agressive program of contact with these sources. Again, this will be an ongoing process—first to make referral sources aware of the services your program will offer, and later to ensure that they receive appropriate feedback (within the limitations of confidentiality regulations) on clients they have referred and that the referrals they are making are appropriate ones.

It may be desirable to develop formal agreements with other service providers regarding referral procedures, client eligibility, reimbursement for services, and information sharing. In some States formal agreements are mandatory prior to licensing. The advisory committee can be helpful in identifying important referral resources and in facilitating development of cooperative agreements.

Administrative and Management Issues

Decisions about the services to be offered and the type of care your program intends to provide will have implications for a broad range of administrative and staffing issues. You should be aware that sound fiscal and operational management procedures are necessary to ensure program quality and program survival. And the implementation of such procedures requires careful planning to ensure that adequate resources have been forecast.

The following discussion is intended to highlight very generally the administrative issues that must be addressed by virtually all programs, in addition to State and professional certification, licensure, and accreditation requirements. The elements included in this section are drawn primarily from the *Program Standards for Alcoholism Treatment* manual, State guidelines for program planning, and suggestions from specialists in developing alcoholism treatment programs.

ORGANIZATIONAL STRUCTURE

Unless your program is sponsored by an existing incorporated agency or organization, an organizational structure must be developed and procedures for incorporation followed. The organizational structure will vary by program type and setting. Documents that describe the administrative framework, or in the case of a private agency, a charter, constitution, and/or bylaws that meet State legal requirements, are necessary. Most programs have a governing body that makes program policy and an executive director who is responsible for operating and administering the program. A business manager is a key program staff member as well. Many programs continue to have an advisory committee. It is vital to identify the lines of authority and responsibility prior to opening the doors of your program.

The governing body. The administrative regulations, bylaws, charter, or constitution of your program must define the authority, responsibilities, and tasks of your governing body. The governing body should function as the agency review board and be distinct in composition and function from the operating staff and administrators of the program. It should exercise authority for the overall conduct of the program, set policy, engage in planning and fundraising functions, and review program operations and performance. A functional committee structure is often used to accomplish these tasks. The governing body should establish and regularly review the program's regulations and procedures, as documented in a policy manual and used as a guideline for the daily operation of the program.

There must be written policy for scheduled meetings, quorum requirements, minutes of meetings, appointment of its members, election of officers, terms of office, size of the group, and appointment of committees. This group should issue an annual report summarizing the program's activities, accomplishments, financial status, audit results, and conclusions of any evaluation studies.

Who should make up the governing body? There should be representation from the community. Community members who can provide support to the program in the key areas of fundraising and who are in a position to assist the program in developing and maintaining relationships with key referral agents should be identified and included in the group. Certainly, recovering alcoholics and representatives of special population groups to be served by the program should be included. People knowledgeable about alcoholism recovery will be important contributors. Other suggested members for the governing body include a businessperson or accountant, a lawyer, a banker, and an elected official. Your community and particular program goals may suggest additional membership needs.

An active, cooperative governing body is an indispensable resource to a program and to its administrators. Establishing and maintaining a sound working relationship with such a body is an ongoing process; one that will change and evolve as your program becomes established. Initially, the group may need to convene frequently to ensure that program requirements are fully developed and implemented. A continuing partnership between the governing body and program administrators will require time, commitment, patience, and skill. Governing body members and program staff are individuals who will bring valuable experience, attitudes, and ideas to your program. In addition, they will bring all the human foibles—jealousy, anger, rivalry, impatience—to the governing process. Identifying and training governing body members is an important and vital task, as is recruiting and keeping a qualified executive director for your program. The development of a balanced, mutually supportive relationship between the governing body and program administrators will be a challenge that must be met for program effectiveness.

Executive director. The separation of policy from daily operation and administration of the program is necessary to ensure the knowledgeable and sensitive policy guidance of the governing body, while allowing for the administrative and management skills of the executive director. This dichotomy also allows for objectivity in all decisionmaking aspects of program operation.

The executive director is responsible for implementing budgetary and policy decisions and is typically a full-time staff member. This individual will use the policy manual as a framework for the performance of operational tasks by all program staff. The manual will also be the source of documentation for program compliance with established standards.

The executive director should be knowledgeable about alcoholism, alcohol-related problems, and the recovery process. He or she should have administrative and personnel skills and experience. Finally, because the level of performance of the total program depends upon the capacity of this individual, selection of an experienced and empathetic person with much understanding of people is critical.

Business manager. As stated earlier in this guide, many alcoholism treatment programs fail because of poor financial management. It is recommended that you include an experienced business manager on your program staff. Your program must be financially sound and stable.

Your program must have an accounting and financial management system that allows for the projection of revenues and expenditures for each fiscal year, processes for determining, collecting, and reporting any fees and for analyzing and adjusting expenditures, preparation of regular financial statements, and identification of cost-saving procedures. The need for setting up an adequate system cannot be overstated. Third-party payers are going to assume a greater future role in providing funds for services rendered, so you need a good financial management system to show them where the money is being spent and how effective your program is in treating clients. The business manager will bring the sound fiscal skills to accomplish these tasks. Working closely with the executive director, this individual will be a key member of the program team, providing the governing body and program staff with a solid foundation of fiscal control and management.

Advisory committee. Programs may maintain an advisory committee in addition to a governing body and operations staff. In these cases, the advisory committee serves important functions for all program entities. For example, the advisory committee can be asked to conduct special community surveys, develop recommendations regarding special population groups, advise the governing group and program administrators about ways to improve program services, help develop and maintain good community contacts, assist in the recruitment of volunteers, and identify community outreach approaches and contacts.

Maintaining an advisory committee requires that you clearly identify the roles and responsibilities of this group. This effort will help ensure that the lines of authority within your program generate mutually supportive and beneficial results—separating advisory input from policy development and program review from the day-to-day program operations.

STAFFING AND PERSONNEL MANAGEMENT

A staffing plan that supports the program goals and the services to be offered has to be developed. It is important to decide what types of professional staff will be needed to deliver all of the

planned services, and to develop labor hour estimates that include time for ongoing training and administrative and supervisory duties. As noted earlier, a wide range of individuals are involved in providing alcoholism treatment services—from physicians to social workers to certified alcoholism counselors. Most programs employ a multidisciplinary staff, and most include alcoholism counselors who are recovering alcoholics. It is also advisable to select staff who represent the demographic and cultural mix of the prospective clients. Many States have requirements that certain types of staff be assigned certain duties in treatment programs, and such regulations should be explored. In addition, you should also review credentialing requirements for alcoholism counselors in your State; a model set of credentialing standards has recently been issued by NIAAA and might be useful to you in developing hiring criteria (see Appendix A for ordering information). The *Program Standards for Alcoholism Treatment* manual calls for programs to require counselors to be credentialed or to be working toward that status; in States where no credentialing process is available, the manual suggests that the program set minimum standards for its counselors.

Personnel policies and practices. Good management does not happen without good planning. Thus, it is important to consider the resources necessary to ensure effective supervision of professional and nonprofessional staff. Personnel policies and procedures have to consider the following: employee recruitment, benefits, and promotion; training and staff development; safety and health; employee assistance; disciplinary systems, suspension, and termination; grievance mechanisms; wages, hours, and salary administration; rules of conduct; performance appraisals; and equal employment opportunity (EEO) and affirmative action policies. The written job description of each position should specify credentials required for employment in that position and the general duties and responsibilities, minimum levels of education and training required, related work experience required, reporting and supervisory responsibilities, and salary range of the position.

Supervisors and managers should be provided with basic information on how to interview and recruit staff, how to set performance standards, and how to provide performance reviews. It is important to recognize that particularly in the human services, managers and supervisors may not have had any academic training in management techniques. Therefore, your program may need to provide for such training.

Training and staff development. Ongoing training of staff is generally recognized as essential in programs providing direct services to alcoholics. This may be accomplished through an in-service mechanism, or through program-supported attendance at alcoholism training programs. If an in-service program is anticipated, you will need to consider who will perform the training, how the service program will be operated while staff participate in training,

the subject areas to be covered in training, and how the successful completion of the training will be measured.

Use of volunteers. Traditionally, the alcoholism field has made greater use of volunteers than have most other healthcare services. If you anticipate using volunteers in any capacity, it is important to develop detailed guidelines regarding how they will be recruited, screened, supervised, and used. In addition, it will be necessary to develop a volunteer training program; particularly when volunteers include "alumni" of the program, it is important to define clearly the role they are to play, to whom they are to report, and the nature of their interaction with staff and clients. It is also important to consider carefully how volunteers will be systematically provided with feedback.

When clients are involved as volunteer peer counselors as part of their own treatment process, it is important to establish controls that safeguard clients' rights and ensure that such work complies with local, State, and Federal laws and regulations. Compensation may consist of services rendered by the program. However, if the client is filling the function of a paid position, it will be necessary to provide a wage.

You should also investigate insurance coverage and legal requirents that will protect the program against claims resulting from actions or inaction of volunteers. A personnel recordkeeping system should be established for volunteers, just as for paid staff. Depending on the scope of the program's intended use of volunteers, it may also be advisable to develop a volunteer recruitment plan. A great deal of information has been developed on the use of volunteers; Appendix A provides several references that offer suggestions for recruiting, training, and managing volunteers.

RECORDKEEPING AND REPORTING

Procedures for clinical recordkeeping will need to be established and forms developed, specifying what is to be included in the clinical records, who is to make entries, when they are to be made, who will review them, when they will be reviewed, and mechanisms for their safekeeping. Programs must ensure that they comply with Federal confidentiality regulations (43 C FR Part 2) and authorizing legislation (42 U.S.C. 290dd-3).

In addition, you must meet the need to collect and report data required by licensing and funding sources. As noted in the *Program Standards for Alcoholism Treatment* manual, "virtually any funding or licensing source requires that reports be submitted on a periodic basis. Governmental agencies may require a monthly progress report along with a report of financial transactions. Foundations may require only a quarterly report and a final report. Insurance carriers may require only an annual cost report." You must consider such issues as who will develop reports and what sort of review process will precede submission. "Reporting requires a substantial outlay of time and money," the manual observes. "Programs should budget and plan accordingly."

PROGRAM EVALUATION

The data collected as part of the required recordkeeping and reporting activities will also be useful in ongoing program evaluation. This will entail analysis of overall program effectiveness and identification of areas needing refinement, based on such data as number of clients served, types of services provided, attrition, client outcome, followup outcome, and staff utilization. There should be an ongoing evaluation of whether the program is actually meeting the goals established at the outset of the planning process. You must consider what data should be collected, what methods will be used, how program activities will be documented, who will collect the data, and who will perform the analysis. An analysis framework should be developed that describes how data are processed and analyzed, the procedure for measuring program outcomes, how data are used to measure each of the program's goals and objectives, and how the cost effectiveness of the program will be assessed.

Evaluation data are critically important to the long-term success of your program. Such data ensure that successful aspects of the program are identified and continued and that problem areas are identified and remedied. The governing body, advisory committee, or both may play a role in reviewing the evaluation data and revising program policies and directions on the basis of the findings.

QUALITY ASSURANCE

You must consider development of procedures to assure quality of treatment services, medications dispensing, and food services as well as the protection of clients' rights. Methods for identifying utilization-related problems should include the following: written criteria for appropriateness of admissions; criteria for services continued beyond the program's established normal timetable; procedures for identifying and correcting delays in the provision of services; and documentation of the program's utilization review conducted on a periodic basis. According to the *Program Standards for Alcoholism Treatment* manual, "utilization reviews ensure that the services provided by the program are effective and appropriate to the specific needs of the program's clients. Such reviews involve studies of the effectiveness of each service provided and of the overall efficiency of the program in accomplishing its objectives. Utilization review is a primary cost-containment requirement of third-party payers."

As part of this ongoing monitoring process, you need to identify methods to ensure that medications are administered in accordance with accepted and statutory clinical practice under the authority of a physician. In addition, programs that administer medications must have written pharmaceutical standards, as well as policies and procedures to ensure that medications are stored, dispensed, and administered in accordance with accepted pharmaceutical standards, rules, and regulations.

Programs that provide dietetic services must establish procedures and plans for meeting nutritional goals for program clients, developed with review and approval by a qualified dietitian and providing for the special needs of specific clients and the maintenance of special dietetic information in client records. Programs offering transportation services must establish safety and management guidelines.

In order to ensure that client rights are protected, you should develop policies regarding use of physical restraint, use of client labor, mechanisms for review of complaints of alleged neglect and abuse of clients, and participation of clients in research. Recommended policies and review procedures related to these areas are included in the program standards manual.

FACILITIES AND LOCATION

Locating a site and facility within the community that can accommodate your program requires that it be accessible to the target populations the program may serve and that it meet applicable State and local fire, safety, health, and building codes. Compliance with local zoning ordinances is often necessary also. Meeting licensing and zoning requirements can take months depending on your local environment. When inpatient or residential services are to be offered, compliance with additional State regulations will doubtless be necessary.

You must also recognize that your program location and facility will exist within a broader community environment. Your community outreach activities, needs assessment, and planning process will help you secure the support of surrounding neighbors, other service agencies, and the business community for the location of your program. Securing a lease, purchasing a site or facility, or construction of a facility can be greatly expedited with the assistance of a banker and lawyer who are members of your governing group. Careful inspection of the condition of an existing building is also necessary so that you identify and plan for all needed improvements, maintenance costs, and expansion needs.

In selecting a site, you should plan for a well-lighted, cheerful environment, readily marked and inviting to clients and their families. You should see that adequate private space is available to ensure the confidentiality of counseling sessions, that an area sufficient to accommodate group counseling is available if needed, and that administrative areas are provided for. The JCAH manual identifies in detail the facilities requirements alcoholism programs must meet in order to receive accreditation.

FUNDING AND FUNDRAISING

Critical to program planning is the answer to the question, Where will the money to run the program come from? The needs assessment information and input from the governing group and/or

the advisory committee can be expected to provide some leads to programs not seeking public funds or seeking to supplement public funds with money from other sources. Part of your program plan should be a development plan identifying the tasks, timetable, and responsibility for program development, or fundraising, activities. Fundraising is an ongoing process, and time and resources must be invested in this aspect of program operation. Because fundraising has become a major concern of alcoholism treatment programs in the 1980s, a number of guides on the topic are available (see Appendix A for ordering information).

The visibility and credibility of your program in the community will be a significant factor for successful fundraising efforts. Potential donors must have confidence in your program and believe that the services you provide are worthwhile and beneficial. In addition, you must define your fundraising needs and goals, whether for special projects, expansion of facilities or services, or ongoing operational revenues. Once you have determined your needs and goals, there are many approaches you may take to raise necessary funds. Members of your governing body, in particular, should support your program in this area through the recruitment of individuals who can raise funds for your program, through awareness of where local, State, or other funding lies and the ability to access that funding, or through direct contributions. Examples of some fundraising approaches you might explore include these:

- *Use of the local media*—public service announcements on radio and television, talk show appearances, news articles
- *Public appearances*—speaking engagements before community and religious groups, service clubs and commissions, and at conferences
- *Paid advertising*—signs on buildings or in other facilities, billboards, telephone directory ads, newsletter and commercial paper ads, television and radio ads
- *Direct mail*—letter solicitations targeted to specific groups such as lawyers, physicians, and country club members with followup telephone contact
- *Personal contact*—contact with individuals by members of the governing group, advisory committee, or others recruited to raise funds.

In addition to seeking outside funding, you should also seek to project expected revenues from reimbursement for services, and to develop program procedures that will maximize such reimbursement. The imposition of client fees is an appropriate way to generate revenue for many programs. Fee schedules that are consistent with other local service providers should be maintained. Sliding scale fee systems are widely used. Any program billing structure must be consistent with the program philosophy and goals, applied consistently, and approved by the governing body.

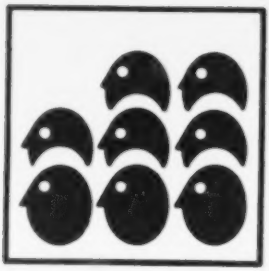
The *Program Standards for Alcoholism Treatment* manual recommends that programs routinely gather information about reimbursement and then identify and garner third-party dollars. "In a practical way, programs should become familiar with the coverage and benefits offered by local businesses and manufacturers. Insurance plans for local government employees should be reviewed. Changes in medicare/medicaid rules and regulations should be monitored. The program should maintain and periodically update a list of third-party payers, including a schedule of benefits and eligibility requirements; determine eligibility of all clients for third-party coverage; make sure to bill all third-party payers under legal obligation or authorized to pay all or part of fees for service; monitor and follow up on third-party billings; identify potential clients eligible for reimbursement; and actively market services to clients eligible for reimbursement."

BUDGETING AND COST ACCOUNTING

Development of a realistic, conservative budget is critical to program success, according to most experts. You must look very carefully at the expected revenues and the anticipated expenditures and make adjustments in the scope of the program as necessary. The budget process should involve the governing body, the executive director, and the business manager. Periodic reviews of the budget should be part of the operating procedures of the program.

In order to carefully monitor the budget, cost accounting and tracking systems must be developed and implemented. These include a system for tracking program costs per unit of service, so that the executive director can determine if certain types of services are disproportionately costly in relation to other program components; this information also provides a basis on which fees can be developed. Additional information on the procedures to follow in developing cost monitoring and fee systems is available in the program standards manual. This document also contains a section outlining desired practices in budgeting and cost accounting, covering the following areas: preparation of annual revenue and expense budgets; identifying funding sources and procedures for monitoring both revenues and expenditures; establishing a formal process for forecasting cash flow; choosing an established accounting system that will document all transactions; establishing procedures for tracking staff time; developing contracting procedures to ensure that consulting and cooperative agreements are fulfilled and developing cash handling controls; and maintaining records necessary to comply with audits and to conduct periodic financial audits.

In addition, NIAAA has developed a "turn-key" accounting system for alcoholism programs providing outreach, referral, and counseling services. This "turn-key" system includes procedures and forms that most programs can put into place with no modification. A cost accounting manual is also available from the American Hospital Association that provides a standardized system applicable to many treatment programs (see Appendix A for ordering information).



Serving Special Populations

Special Populations

Untreated alcoholism has devastating health and social consequences for its victims, their families, and their communities. Research suggests that members of a number of population groups, defined by sex, age, race, and ethnicity, may be particularly underserved by alcoholism treatment programs. These groups include elderly people, women, youth, black Americans, Hispanic Americans, the multidisabled, Asian/Pacific Americans, and American Indians. The planning for and operation of any alcoholism treatment program will require consideration of the special needs of these underserved and at-risk populations.

This section briefly highlights research findings and actual program experiences that are applicable to treatment program development for underserved populations. You may decide that your program will focus on one or more of these potential client groups. Realistically, all programs must be prepared to serve individuals from many walks of life.

The information previously presented in this guide on planning, development, and operation of an alcoholism treatment program is fully applicable to programs serving all client groups. Reaching and serving special populations, however, will require the removal of unique barriers and an awareness of needs that, once met, will enhance your program's effectiveness. Also, statements about the practices, beliefs, and values of particular special population groups may be applicable to many if not all groups of individuals regardless of ethnicity and cultural background. Such statements are made in light of research and experiential evidence of their particular significance for treatment programming for certain populations.

This special populations section presents information on needs assessment, outreach, treatment considerations, and special administrative issues specifically pertinent to elderly people, youth, the multidisabled, American Indians, black Americans, Hispanic Americans, Asian/Pacific Americans, and women. Appendix A includes references to a variety of materials that can provide you a great deal of additional information. Organizational resources listed in Appendix B can also help you tailor alcoholism treatment to special client groups.

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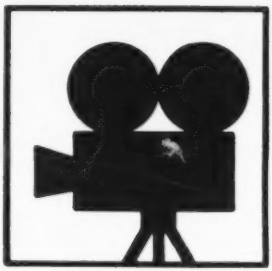
Elderly

NEEDS ASSESSMENT

Despite the fact that drinking appears to decrease with age, there are still a significant number of elderly who are problem drinkers. Estimates of alcohol problems or alcoholism in the general population of elderly range from 2 percent to 10 percent. Identifying alcohol problems among elderly people is especially difficult, however, because many of the indicators that apply to the general population are not as applicable to the elderly population. Physicians often misdiagnose alcoholism in elderly patients since the symptoms are very similar to those associated with other conditions more frequently experienced in old age, and the attitudes of many caregivers result in a failure to translate awareness of drinking problems in an elderly client into diagnosis and treatment. In addition, older people may be protected by family members reluctant to address alcohol problems. You may be confronted with a population at-risk that is hidden and undetected. As a result, you can take a variety of approaches to needs assessment, including use of existing sources of demographic data that may be available from local planning agencies and the State Alcoholism Authority. Reviews of hospital records, reviews of police arrest data on the aged arrested for public drunkenness or driving while intoxicated, and surveys of local agencies serving the aged or the alcoholic may help to identify the nature and scope of the problem of alcoholism among elderly people in your community.

OUTREACH

Since the elderly problem drinker is difficult to identify, you will be particularly challenged to develop effective outreach and community education methods. Outreach activities might include education to heighten the awareness of caregivers who frequently come into contact with elderly people so that they will consider the possibility of alcohol-related problems and make appropriate interventions or referrals. Health aides and home care workers who go into the elderly person's home need to be aware of symptoms of alcohol abuse. Hospital social workers and discharge planners are other caregivers to be informed about alcohol abuse among the elderly population. Information campaigns might also be directed to family, friends, neighbors, and associates of elderly people to heighten their awareness of the symptoms of alcohol abuse and to inform them about how to obtain help.



Outreach and education might use the resources of volunteer groups such as the Retired Senior Volunteer Program (RSVP), the American Association of Retired Persons (AARP), and the Gray Panthers. Audiovisual materials, posters, and information booklets can also be made available at places frequented by elderly people, such as launderettes, bingo parlors, restaurants, and drugstores. Public service announcements on television have been effective in reaching the elderly population and can be targeted to adult children and spouses of elderly alcohol abusers as well. Information can also be presented directly to elderly populations through nursing homes, retirement communities, senior centers, golden age clubs, and church groups. Public housing in some areas may house a number of elderly people at risk for developing alcohol problems, and would be another site for awareness campaigns. Outreach and awareness programs to elderly people in rural communities may differ greatly from those used in urban areas. Residents of rural areas may be less likely than their urban counterparts to use social service agencies or to accept help and intervention by outsiders. Experts in rural programming stress the need for more informal information efforts, noting that community opinion leaders may or may not be the area's appointed leaders.

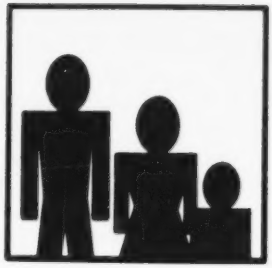
TREATMENT CONSIDERATIONS

Involving elderly clients in planning their treatment is very desirable, both as a means for gaining cooperation and for restoring self-respect and self-esteem. Treatment plans might involve contracting with the client for specific goals and subgoals, and setting approximate timetables for their achievement. Planning daily schedules for work, rest, and therapy or group meetings is helpful, as large blocks of unscheduled time should be avoided. Elderly persons in particular may need help in finding positive ways to use time formerly scheduled around work and family activities. Aftercare planning is considered crucial by experts, and this early client involvement lays the groundwork for the client's discharge from the program.

Elderly people may require the full range of services needed by other alcoholics: detoxification facilities, residential and outpatient care, alcohol education, and individual and group therapies. The therapy of elderly alcoholics should differ in emphasis, however, in that a relatively greater need exists for a wide range of medical services, social therapies, and assistance services.

Medical services can range from acute to long-term care. Awareness and management of drug use, nutritional requirements, and chronic health conditions may be needed. Treatment of elderly clients should emphasize group and recreational therapy techniques,

since the support provided by others may be a critical element for recovery. Specialized groups for elderly clients may include exercise and relaxation, and assertiveness training. Involving recovering elderly alcoholics in the treatment programs of other elderly alcoholics may be helpful. Elderly clients report that such contact is highly beneficial, particularly in the early stages of treatment when denial and feelings of guilt and shame are paramount.



The presence or absence of family involvement with an elderly alcoholic's recovery is an important indicator of successful treatment. The family should not be narrowly defined as blood relatives as is usually applied to younger alcoholics. Family substitutes are crucial to the well-being of an elderly person whose original family may have been scattered or lost through separation or death. Outreach and education efforts for these family members are necessary as well.

Elderly alcoholics often require help ranging from housing to hearing aids. Linking the service systems for the alcoholic and for the aged will help establish a complete treatment care continuum for each client. The agencies with which such relationships should be established can be identified through community service directories, community agency surveys, and senior citizens councils.

In addition to treatment designed to their special needs, elderly persons require strong aftercare services. Effective followup and aftercare may include home visits by your staff, friends, and neighbors. Outpatient programs that focus on building social supports and developing new relationships are suggested. Treatment specialists also note that there should be an emphasis on the reintegration of an elderly client into the family where possible; support for the elderly person in organizing leisure time; recognition and development of long-unexpressed talents, hobbies, and skills; and management of discretionary funds. Other suggestions include group activities for some clients, involvement in "alumni" groups who provide transportation and emotional support to the elderly where necessary, and involvement in AA meetings.

ADMINISTRATIVE ISSUES

There are a number of practical considerations in offering effective treatment services for elderly people. Your treatment site ideally should be accessible via public transportation and provide for ease of access by those who have physical restrictions. Safety is another concern of elderly people, who may be afraid to leave their homes after dark. Treatment centers located in high-risk neighborhoods might offer an escort to the program or offer daytime counseling to elderly clients. Former clients may be recruited to serve as

hosts and drivers, and volunteers or agencies providing service to the aging may assist with transportation and organizing carpools.

Elderly clients may be financially unable to pay for treatment. Your alcoholism center must be familiar with sources of funding through medicare, medicaid, Title XX, other State sources, private insurance coverage, and other community resources. It may also be necessary to provide elderly clients with assistance in completing the forms necessary to receive coverage or reimbursement.

With respect to staffing, experts report that volunteers are particularly useful in serving elderly clients. These volunteers can supplement the services of your program during the early stages of treatment and in the critical aftercare period. The elderly alcoholic gains opportunities to socialize, develop new skills, increase understanding and awareness of alcoholism, and enhance self-esteem through the contact and support provided by volunteers.

A major factor in diagnosing, intervening with, and treating elderly alcohol abusers is the attitudes of caregivers. Both the alcoholism worker and the geriatric worker require knowledge of and sensitivity to the social, psychological, and physiological aspects of the aging process as well as the course of alcohol abuse. Thus, staff training sessions should focus on such issues.

Youth

NEEDS ASSESSMENT

National surveys indicate that almost one in three youth could be classified as an alcohol misuser or problem drinker. Alcohol misuse or problem drinking among adolescents is more often associated with episodic, heavy drinking than with alcoholism. Teenage problem drinkers usually do not suffer from the many physical disabilities associated with alcoholism, but they do experience other severe, acute consequences such as serious traffic accidents, trouble in school, and difficulties in relationships with peers and their families.

The extent of alcohol use and problems among youth has been well documented in a variety of national studies. Identifying the adolescent alcohol abuser at the community level may be addressed by surveying agencies, school officials, youth organizations, and health centers providing services to youth or involved in youth-related activities. Data on youth-related traffic accidents, court referrals, and delinquency rates and crime, as well as truancy rates may all provide important information regarding youth problem drinking.

In addition, you should be aware that the children of alcoholics are at high risk for developing problem drinking. These children are more likely to have school problems, display antisocial behavior, and have lowered self-esteem.

OUTREACH

In spite of increasing concerns voiced over the consequences of adolescent alcohol misuse, human service professionals continue to have problems reaching and treating this population. A major reason is that young people often do not see their alcohol use as a problem. Even when youthful alcohol abusers do seek help, many are unaware of the various services available to them; others refuse to go to established agencies out of mistrust, embarrassment, or alienation. Still others fear parental reactions if their problems are revealed.

As a treatment program planner, then, you must devise means of reaching out to these youth who may be unmotivated or reluctant to use available services. One effective approach is to consider developing youth programs in which there are a wide range of professional services available and opportunities for personal growth, educational and vocational development, recreation, and creative expression. By offering such help, your program can reach and involve a large group of youth who are alcohol users. Providing alcohol treatment within the

context of a youth center has another appeal to young people. It provides nonstigmatizing access to alcohol-related services.

It is also essential to make special outreach efforts to adolescents. One of the most effective ways of reaching young people is to have members of the treatment program tell their friends about it. Some programs go into the community to reach young people. Mobile units or staff go to shopping centers, parks, recreational areas, or other places where young people congregate. They often use music as a vehicle for initiating communication, and later discuss issues or problems of concern. Community outreach programs have successfully recruited sports figures as well to attract youth to alcohol education events.

School-based outreach and education programs have been increasingly successful in helping youth alcohol abusers. Recognizing that adolescents may not want to discuss their problems with adults, trained peer leaders provide support and referral services and help organize educational programs within the schools.

Outreach must also be targeted toward professionals who work with youth. Teachers, recreational workers, family planning counselors, and others need to be prepared to deal with the problems related to alcohol. These contacts also serve to develop a network of agencies that can work in an integrated fashion to help youth with their problems.

TREATMENT CONSIDERATIONS

Adolescents may reach a treatment program through a variety of pathways: self-referral, or referral by schools, hospitals, the police, the court system, physicians, or family members. Typically, intake and assessment includes routine psychological and physical workups. Family members may also participate in this assessment process in order to find out as much as possible about the adolescent and the issues surrounding their child's or teenager's chemical use, to receive support and information on how chemical dependency affects the family, and to gain a solid impression of what their role will be throughout treatment. In addition, program staff may want to gather information from as many other sources as possible—school, friends, court system, and family physician.

While alcohol and other drug problems will be directly addressed in the treatment plan, they are to be viewed as part of a larger cluster of problems for most adolescents. Thus, treatment plans may focus on educational and vocational issues, as well as feelings, conflicts, and behavior patterns. Many programs also focus on strengths in addition to problem areas in an effort to encourage youths to develop these strengths as well as to remediate problems.

Experience has indicated that the availability of a comprehensive range of services and activities is essential for effective treatment of youth with alcohol-related problems. In setting up serv-

ices for youth, it is important to remember that adolescence is a period of rapid growth and development. Youth expend considerable psychic and physical energy during this period of change, and many experience personal, interpersonal, or environmental problems that interfere with their development.

Basic professional services in mental health and physical health are necessary. Mental health services may include testing, crisis intervention, individual as well as group counseling, peer counseling, and theme-centered groups. The availability of family therapy and counseling in youth programs is very important, for it is often within the family context that many of the antecedents of alcohol abuse are established and patterns of abuse and other self-destructive behavior are learned. Family members' involvement in treatment can also help ensure that youths return to more functional home environments.

In addition, a range of activities that provide opportunities for personal growth, recreation, creative expression, and educational and vocational development should be available. For example, career counseling services for youths may help resolve the problems they have had in school and assist youth in making realistic career choices. Some youth in treatment will have dropped out of school and will benefit from instruction geared toward their specific educational needs. Youth may benefit from advice, counseling, and representation on legal problems and in civil and criminal cases. Special emphasis should be given to educating young people about their rights and responsibilities under the law. Your treatment program can also develop special workshops that help substance-using young people and their families understand the adolescent developmental process. Issues regarding their developing sexuality are often paramount with young people and can be a focus of individual and group sessions as well as seminars. Ethnic and cultural enrichment workshops and special events can develop adolescent awareness and pride in their own heritage. Activities that offer young people the opportunity to engage in constructive physical activities and to establish positive peer relationships should also be part of your overall treatment program. Youth work and leadership training activities can be developed for youth who are seeking opportunities to be of service to others. Adolescents can assist staff, take part in outreach activities, provide introductory information about programs, orient new clients, or tutor peers.

As part of an aftercare plan, many existing programs require attendance at AA meetings or other self-help groups. Frequently special aftercare groups are formed. These groups can provide reassurance and support to young people in coping in a more autonomous way with the daily problems that life presents and in maintaining a new and constructive lifestyle. Care must be exercised, however, not to make the adolescents dependent on your pro-

gram and its staff, thereby robbing them of the opportunity to be autonomous.

ADMINISTRATIVE ISSUES

If your program will offer services to youth, you must be cognizant of a number of issues that are particularly important in getting young people to seek and complete treatment. Many young people will avoid programs for which parental consent is a requirement. Parents should be involved in the treatment process, but the requirement of parental consent does not necessarily assure parental involvement. Parental involvement should occur when it is appropriate and when youth are willing to have this involvement; if it is forced, your program may have difficulty in reaching adolescents. The cost of services also limits alcohol treatment services for youth and is related to confidentiality and parental consent. There is no simple way to collect fees from youth in a manner that does not jeopardize confidentiality or does not become a barrier to continued program involvement.

Physical location is also important. Programs for youth should be located in areas easily reached by public transportation and highly frequented by youth. The hours of program operation will also affect accessibility to youth. Because young people are often required to be home during the evening hours, activities and programs specifically for this group should be planned for the afternoon. Youth who have left school may be a target group for your treatment program. For those youths who are working, flexible program hours may be necessary. The appearance of the facility can also effect the accessibility of a program. The design should be attractive to youth with bright colors, posters, and a relaxed atmosphere.

The Multidisabled

NEEDS ASSESSMENT

More than 36 million people in this country are physically or mentally disabled, and there is growing evidence that this population is particularly vulnerable to alcoholism and related problems. Until recently, the multidisabled alcoholic person has been largely overlooked, both by the rehabilitation services system and alcoholism agencies. Failure to identify and treat alcoholism may well constitute a serious impediment to successful rehabilitation.

A number of local surveys and research studies have indicated that alcoholism—at least for some groups of disabled people—may be much more prevalent than among the general population. Assessing the needs of the multidisabled at the community level will require the involvement of existing treatment programs, organizations of the handicapped, rehabilitation agencies both public and private, and health care providers.

OUTREACH

Increasingly, existing alcoholism treatment programs, rehabilitation agencies, and vocational programs for the multidisabled are recognizing the need to identify and treat alcohol and other substance abusers among their client groups. The disabled receiving treatment within a spinal cord injury rehabilitation center, for example, can benefit from the alcohol unit within this center while receiving ongoing physical and occupational therapy. When disabled people become substance abusers (or when substance abusers become disabled), there is seldom an alcohol or drug abuse treatment program available that can help them.

Overcoming the barriers to treatment for the multidisabled necessitates the education of the substance abuse and rehabilitation communities, as well as outreach to the disabled individual. The multidisabled substance abuser is caught in the gap of services. Rehabilitation agencies ignore them on the grounds that they do not understand substance abuse. Substance abuse agencies, on the other hand, often ignore them on the grounds that they do not understand the nature of disabilities. The training and education of these professionals toward the integration of service delivery for the multidisabled can be an essential element in effective treatment and recovery. In addition, the disabled person is frequently isolated and frustrated in attempts to seek help. Preconceptions about disabilities, stereotyped responses, inaccurate knowledge, and erroneous belief systems all play a part in influencing the behavior of the disabled. Outreach efforts to these individuals are

essential and may include presentations, programs, and coordinated projects within rehabilitation agencies, advocacy groups for the disabled, the Veterans' Administration and the Social Security Administration, and through other agencies serving the multidisabled.

TREATMENT CONSIDERATIONS

Important to treatment planning for multidisabled clients is the early identification of alcohol abuse, ideally during the evaluation interviews and treatment planning provided by rehabilitation agencies, physicians, or other groups. Seldom is alcoholism information recorded on client intake forms, however. Participating in a separate alcoholism treatment program at the same time clients are involved in a rehabilitation program may be considered too taxing for some individuals. In other cases, rehabilitation activities can be used as a means of resisting recognition of an alcohol problem.

Designing the treatment services to the specific needs of the multidisabled is essential and requires close collaboration with agencies serving the disabled. For example, some programs prohibit use of drugs. However, when dealing with the disabled population, it is sometimes impossible to conform with such a rule. A client with epilepsy may require medications that affect the central nervous system to stop the seizure activity, and in this case abstinence from drugs is not feasible. In other cases, drug use may be of special concern. Valium, for example, is frequently prescribed for the disabled. Combined with alcohol, the mixture can impair judgment, reaction time, and coordination. Treatment planning for the disabled requires careful coordination with other rehabilitation programming and health care regimens to assure that substance abuse concerns are part of an overall service delivery approach.

The isolation, fear, anxiety, and frustration in coping with the demands of daily living as well as with physical and mental disabilities may combine to create the additional disability of alcoholism. Treatment services for the multidisabled must emphasize the need to diminish the stress experienced by these individuals. Techniques may include relaxation training, problem-solving skills development, assertiveness training, and development of skills to improve self-image. Group and individual counseling, behavior modification methods, family therapy, and AA participation are also part of the treatment process. Pressing problems of housing, vocational training, financial support, transportation, and mobility are often part of the range of support services needed to return the disabled substance abuser to the community. In addition, ongoing physical and occupational therapy may be required for many during and after the treatment period.

Establishing a network of support contacts within the commuty is particularly important in assisting the disabled to return to the community. Aftercare support groups, patient newsletters, and volunteer activities have been successfully initiated by treatment programs.

ADMINISTRATIVE ISSUES

For the physically impaired alcohol abuser, wheelchair ramps, specially designed restrooms, and lowered drinking fountains and telephones are facility requirements. The physically impaired individual may require additional consideration in scheduling treatment components since dressing, grooming, and use of toilet facilities can take considerably longer for them than for the ambulatory client. Many paralyzed individuals may require treatment for decubitus ulcers aggravated by sitting in their wheelchairs for days while they were drunk. Poor nutrition and bladder and kidney infections can add to the complications. In addition, physically impaired individuals may experience particularly low self-esteem, since many sustained their injuries while under the influence of alcohol. Psychological aspects of working with the physically disabled substance abuser also present special problems. The paralyzed person may try to use his or her disability to manipulate the treatment program, and your treatment team members have to be very familiar with the subculture of the paralyzed person. An ambulatory client goes into treatment to deal with his or her addiction. The paralyzed person comes into treatment to deal with the addiction plus a physical disability that may well have been a result of alcohol abuse.

The hearing-impaired alcohol abuser is often particularly isolated, yet experience has demonstrated that hearing-impaired alcoholics are very responsive to treatment. Programming for hearing-impaired alcoholics must address the unique aspects of the disability of hearing loss by incorporating interpreter services, TTY phones, interpreted audiovisuals, knowledge of the psychosocial aspects of hearing impairment, and special simplified reading materials. Hearing-impaired clients may also require more time than hearing clients to absorb the verbally presented information in therapy sessions. Much of the information presented may be new and conveyed through manual language; thus the client may become fatigued sooner than hearing clients. It may be necessary to extend the duration of treatment for hearing-impaired people.

Vision-impaired alcoholics share with the physically impaired the need for removal of physical barriers in treatment settings. In addition, braille labels and other available materials and technology will assist these individuals to receive information vital to their recovery. Increasing their own mobility is an essential step for visually impaired people. The accessibility of the treatment facility to public transportation is an important consideration. Experience has also shown that these disabled alcohol abusers are usually in poor physical condition, with nutritional and health problems. Recreational activities and physical conditioning programs can contribute to recovery.

Social isolation and a lack of social skills contribute to alcohol and substance abuse problems among mentally retarded individuals. Treatment must be sensitive to the pervasive social isola-

tion and high anxiety levels among this population. In addition, long-term involvement in support groups following treatment is essential to recovery.

The developmentally disabled person may have a wide range of physical, motor, and mental impairments that are permanent and irreversible. Experts who work with developmentally disabled persons focus on developing or modifying behaviors. Treatment of the developmentally disabled alcohol abuser should focus on meeting immediate medical, social, and legal needs, with followup at reentry into the community that may require other social services. In addition, many developmentally disabled people are on medication, and medical supervision is essential. The developmentally disabled individual may also have limited verbal skills and be unable to participate actively in treatment planning or to participate fully in many existing self-help groups.

Educating and training alcoholism treatment personnel about the psychological and sociological aspects of the personal worlds lived by disabled people and to obtain proper insight into their own feelings in order to overcome any fear or stigma they attach to certain disabilities is an important element to successful treatment of the multidisabled.

American Indians

NEEDS ASSESSMENT

The American Indian population, including Aleuts and Alaskan Natives, is estimated at 1.5 million. Within this population group, the alcoholism rate is estimated to be at least twice that of the country as a whole. The Indian Health Service has reported alcohol misuse and abuse to be the most widespread and severe health problem within American Indian communities, but few studies have been conducted on the extent of alcohol consumption within the total Indian population. Available data, however, point out certain consistencies in drinking practices and consequences of these practices. American Indian adolescents show a high rate of alcohol misuse. Alcohol consumption is highest among those people in the age group 25 to 44. There is a notable decline in the number of drinkers and the extent of drinking after the age of 44. Death rates attributable to alcohol-related causes (alcoholism, alcohol psychosis, and chirrhosis of the liver with mention of alcoholism) are about eight times greater among American Indians than for the U.S. population as a whole.

In assessing the needs of this special population it should be noted too that there exist widespread misconceptions and biases surrounding the topic of American Indians and alcohol. Adding to the confusion are the different patterns of drinking in various American Indian tribes with diverse cultures, attitudes, and beliefs that affect their patterns of drinking.

OUTREACH

Until recently American Indians living on reservations or in urban areas have generally lacked information about alcohol and alcoholism. Today, American Indian leaders believe that more alcoholism education efforts are needed, especially for young adults. Alcohol education in the schools as well as in the community is being stressed. The involvement of the family unit is also considered essential to alcohol education, prevention, and treatment efforts.

The high value American Indians place on respect for the individual suggests that outreach and educational efforts recognize that direct approaches may be less successful than with other population groups and that the decision and responsibility to act lies solely within the individual. This respect for the individual, however, is tempered by a desire to maintain harmony and a responsibility toward the family and tribal units. For example, an American Indian woman seeking to separate herself from her family or reservation to attend a substance abuse program may suffer chastisement, imposed feelings of guilt, and physical abuse.

TREATMENT CONSIDERATIONS

There is wide variation among American Indians regarding their willingness to disclose personal sex history, childhood experiences, family secrets, finances, and other routine aspects of a psychological or social history. Staff of the same tribe can contribute significantly to the intake process and to the development of an appropriate and effective treatment plan. It is essential that your staff elicit from the client the unique values and attitudes of that person as well, since not all traditional tribal values will be shared by each member of this group. Native tribal healing practices will also prove to be beneficial in the treatment of the alcohol abuser, and discussion of traditional healing with the individual can reveal the attitudes and beliefs crucial to the effective use of such practices.

Psychiatric counseling techniques and referral to AA services are traditional in alcoholism treatment. But experience indicates that AA may not appeal to many American Indians because of its public disclosures of personal problems, dominant Anglo-American religious overtones, exclusion of nonalcoholics, and attempts to influence the behavior of others. Psychiatric counseling often does not work with American Indian alcohol abusers. Programs that have demonstrated success in the treatment of American Indians with alcohol abuse problems are those that have modified the existing AA program. Religious beliefs and values, enhancement of awareness of what it is to be an American Indian, acknowledgment of a shared history of prejudice and suppression are aspects that can be integrated into your treatment program. The American Indian value of noninterference in the lives of others is diametrically opposed to the tendency in Anglo-American cultures to bring aid to those in distress by offering counseling and advice. The use of confrontation therapy also needs to be carefully reviewed as a treatment technique with American Indian clients, for effective as this technique may be with some populations, to many American Indians, it is degrading and destructive of self-esteem. Aftercare planning, particularly for employment and training, must be a component of any program for American Indians. The opportunity to contribute to the support of the family, community, and tribe constitutes a major incentive for maintaining sobriety and should be considered essential to the treatment process. Similarly, for those electing to relocate away from a reservation, greater urban support alternatives after treatment are indicated.

ADMINISTRATIVE ISSUES

The lack of understanding and the discrimination even by well-intentioned Anglo-American alcoholism treatment staff have been cited as interfering with treatment of American Indians. American Indians are increasingly developing and operating their own alcoholism treatment programs, and where such alcoholism treatment programs are available, a higher proportion of American

Indians have entered treatment. The treatment programs that include American Indians in planning, implementing, and organizing their own programs on a community basis appear to be the most promising.

Ideally, the professional staff should include members of the tribe or tribes to be served. If a tribe is relatively small or spread over a vast geographical area or in urban areas, this may not be economically feasible. Emphasis then should be placed on training non-Indian counselors to relate to their clients.

Black Americans

NEEDS ASSESSMENT

There is considerable evidence that alcohol problems have a major impact on black Americans. The consequences of alcohol abuse (homicides, accidents, criminal assaults, and other conflicts with the law), have been extreme for black Americans, especially black men. In addition, black Americans suffer disproportionately from the health consequences of alcoholism, including cancer, obstructive pulmonary disease, severe malnutrition, hypertension, and birth defects. Although cirrhosis mortality rates have generally declined each year since peaking in 1973, black Americans continue to experience disproportionately high rates. Alcohol abuse remains the number one health problem in the black community. Historically, blacks have been underrepresented in alcoholism treatment populations and have had high dropout rates.

Depending on the stability of a given black community and the degree of racial or economic oppression present, the nature and extent of substance abuse may correspondingly increase or decrease. Given the lack of data on blacks and alcoholism in general and the failure of local and State planning processes to identify and meet minority needs in many cases, it is essential that you survey your community and tap community resources that can describe and help define the nature and extent of alcohol abuse in the black population. Churches, social organizations, social service agencies, and individual community leaders may contribute to this effort. In addition, statistical data on alcohol-related crime, cirrhosis mortality rates, and suicide rates can provide baseline information for program planning purposes.

OUTREACH

Individual awareness and community education are prerequisites for effective treatment. A large proportion of blacks tend not to recognize excessive drinking as a problem, to reject the concept of alcoholism, and to accept heavy drinking as a norm. A traditional lack of access to medical services and treatment programs has been associated with resistance to treatment programs, particularly if the program is located in a predominantly white setting. In addition, a disproportionate number of blacks access treatment services in late stages of their addiction. A lack of trust in existing services, greater emotional defenses, unclear cultural mores governing alcohol use, and the failure of recovering alcoholics to return to their communities have been offered as reasons for underutilization of treatment services. Also, studies have found that the rural black family

tends to attempt to treat addicted family members at home, on their own.

Your outreach and community education efforts must enlist the support of the black community. Efforts to recruit the help of black organizations that are respected in the total community, along with agencies that have longstanding histories of representing blacks and serving their needs, will be needed. Influential individuals in black communities, such as clergymen, physicians, educators, and community and civil rights leaders, are prime candidates to enlist in alcohol education and outreach efforts. However, all who participate must be able to communicate in terms their audiences find meaningful.

Education within the black community is also suggested, to include increased knowledge about the nature of the abuse patterns and problems that exist in the immediate community and to assist the community to see that alcoholism is a primary dysfunction and not just a secondary symptom of racism. Education of the community can be accomplished by the extensive use of the media—public service announcements, newspaper articles on alcoholism (particularly in black newspapers), billboards, and pamphlets on alcoholism made available throughout the community in agencies, schools, churches, and commercial establishments. Education of "gatekeepers," those who have contact with alcohol-abusers (i.e., social workers, probation and parole officers, job training staff, doctors, ministers, teachers, community organizers, police officers), can be an effective tool as well. These people can then participate fully in the referral of potential clients to helping professionals.

Your treatment program staff should not wait for the black client to come to them seeking help, or for the referral network to provide total outreach support. Key access points in the community can be utilized in outreach efforts. Many of these access points are culturally specific: bars, barber shops, beauty shops, churches, social service agencies, economic opportunity programs, jails, pool halls. Many of these places may be frequented by the alcoholic. Recovering alcoholics who are well known in the community and who know the community well can be excellent outreach workers and positive role models. Training in diagnostic and intervention techniques is essential, however, before sending them out into the community.

TREATMENT CONSIDERATIONS

Being black and alcoholic imposes dual barriers to treatment. If your program will serve black alcoholics, you cannot ignore the influences of black history and the reality of being a black person in American society. Treatment planning for black alcohol abusers then must consider the minority culture—its history, strengths, values, and attitudes—and should include rapport-building strategies and counseling techniques that take into ac-

count cultural perspectives about eye contact, touching, time, language, social distance, and other patterns of behavior and communication styles. A holistic approach should be taken, treating the alcohol abuse in the context of family, community, and origin.

Experience suggests that the most meaningful treatment services for black alcoholics include individual counseling (selectively using directive, confrontive, and action-oriented techniques with some clients), referrals to supportive programs and services, alcohol education, employment or job placement, family counseling, group counseling, AA groups, and aftercare. Many black alcoholics in treatment may also need help to develop self-esteem and interpersonal skills and with financial assistance and health care in general. Some treatment programs indicate use of special approaches with black alcoholics such as self-management training, meditation and spiritual therapy, recreation, social modeling, reality therapy, and behavior modification.

It is suggested that black-oriented treatment programs consider working closely with AA. Generally, black persons have been underrepresented in AA. Like mainstream treatment programs, AA was founded by and traditionally has served primarily the middle-class white man. However, the essential elements of AA philosophy—sharing of common experiences, mutual acceptance of one another as human beings, and trusting a "higher power"—are all strong elements in the black frame of reference. Increasingly, predominately black AA groups are being organized.

The standard rehabilitation program that has proved reasonably successful with a white middle-class clientele probably stands little chance with a black audience. Alcoholism counselors serving blacks should be trained to be sensitive to black needs and cultural differences with emphasis on counseling the individual, considering his or her background, education, occupation, and income and the various effects of institutions on his or her life. Your treatment program must also utilize the resources existing in the black community. The black religious experience is suggested for an examination of aspects that will provide spiritual and material strengths in the treatment process. The extended family is an underutilized support system that can be used more effectively in treating and educating black clients. Aftercare support systems in the black community are essential for the maintenance of sobriety.

ADMINISTRATIVE ISSUES

Several points are worthy of emphasis with respect to treatment programming for black alcohol abusers. The inability to pay for treatment is an important barrier for blacks. Providing the black alcoholic with treatment personnel who are sensitive to special needs based on the black experience is also important. Inappropriate attitudes and lack of understanding can be significant factors in treatment outcome. In addition, programs without black staff, espe-

cially when located in a predominantly black community, conveys a negative message to potential users of the service. Finally, white control of black treatment programs carries implications for treatment policy and programming that can neutralize effectiveness.

Hispanic Americans

NEEDS ASSESSMENT

The Hispanic population comprises a number of subgroups that differ widely in national origin, educational attainment, socioeconomic status, degree of acculturation, and culture, and may include Mexican Americans, Puerto Ricans, Cubans, Caribbean Islanders, and Central and South Americans, among others. Available information suggests higher rates of alcohol use and abuse by Hispanic Americans, particularly among men, than for the general population. The Hispanic woman is usually an abstainer or light drinker. Evidence indicates, however, that traditional sanctions against female drinkers break down with increasing acculturation. Death rates from cirrhosis of the liver, arrest rates for public drunkenness and drunk driving, and accident rates while driving under the influence of alcohol are all reported to be higher for Hispanics than for the general population. Most information on problem drinking focuses on the Mexican-American subpopulation, however, making it hazardous to generalize from available data to other Hispanic populations for treatment program planning purposes.

Hispanic migrant and seasonal workers constitute a high-risk occupational group, and alcoholism has frequently been found to be a major factor in this population. Recognizing and addressing the needs of these individuals who move within the migrant streams from one State to another will require well-coordinated efforts.

OUTREACH

Generally, Hispanics tend to underutilize health services of all kinds. The Hispanic American community does not make use of available alcoholism services in proportion to its population and the projected incidence of problem drinking. Outreach and community education efforts then are particularly essential in treatment planning.

Until recently, most alcoholism awareness and education efforts in both print and broadcast media were restricted to English and were directed toward the Anglo American. Translating the messages into Spanish removes a basic barrier. Existing programs have successfully used volunteers to provide information that can prevent development of drinking problems, alert family and friends to early signs of alcohol dependency, raise awareness of the role family and friends may play in promoting or preventing drinking problems, and in educating the community about available treatment services. Peer advisers/teachers at the intermediate school level have been utilized in other communities. Alcoholics Anonymous

groups for Spanish-speaking alcoholics are increasing in number in metropolitan areas. Alcohol education programs for drunk drivers is another approach successfully used in raising awareness of alcohol abuse and in referring individual abusers for treatment.

TREATMENT CONSIDERATIONS

Important to treatment planning with Hispanic clients is the need to remove the language barrier, increase sensitivity to their culture, recognize and include the family unit as a supportive network for its members, accept treatment modalities that include folk medicine and healing practices, recognize the alcoholism denial resulting from lack of education and the importance attached to self-sufficiency, and recognize the prevailing belief that alcoholism is a moral weakness rather than an illness.

Family pride, solidarity, and support are important qualities of the Hispanic culture. These virtues, if not properly understood, can become barriers to timely, effective treatment where alcoholism is concerned, however. Alcoholism in the Hispanic culture may not be viewed as an illness or condition requiring specialized treatment, but rather as a disgrace that reflects on all of the relatives and therefore must be hidden. Concepts like assertiveness, detachment, and independence, often effective tools when working with many alcoholics and their families, may not be clearly understood or accepted by Hispanic clients because those concepts may be seen as a direct threat to the family. Treating the whole family as a unit, rather than the alcoholic individually, may be particularly applicable in treatment work with Hispanic clients.

The lack of an accurate understanding of the phenomenon of addiction among the Hispanic population suggests that alcohol education, as part of the treatment services provided by your program, is essential to sustained recovery. This educational service must also encompass the Hispanic woman as well as other family members. The Hispanic woman ordinarily exists in a patriarchal culture and is subjected to a double standard whereby she is often judged more harshly than her husband in regard to alcohol abuse. In addition to her fear of her society's judgments, she often holds the same cultural values and may be reluctant to support or seek treatment services.

Since virtually all treatment programs begin with an acknowledgment of the problem, the importance attached to self-sufficiency can be a serious treatment issue with Hispanic men. If a man admits that he cannot handle his liquor and has a drinking problem, he is also admitting that he does not have control—an admission of weakness. Seeking treatment, particularly from outsiders, may be especially difficult and ultimately unsuccessful if this is not addressed. Hence, there is a need to employ this concept positively with an absence of threat to the person's self-image.

The existence of traditional, culture-specific models of treat-

ment must be recognized as part of the support system of some Hispanic patients. Integrating the counseling and therapeutic techniques of curanderos (folk healers) and espiritistas (spiritists) with conventional treatment procedures can be helpful. In addition, successful treatment and rehabilitation has combined psychotherapeutic support with participation in AA. Hispanic alcoholics are also likely to manifest greater disruption in vocational and economic areas, suggesting the need for referral to assistance services or for specialized, culturally sensitive assistance services within your overall treatment program.

ADMINISTRATIVE ISSUES

The lack of means to pay for treatment is an important factor in the underutilization of a treatment program by Hispanics. Hispanics are less likely to have insurance coverage for alcoholism treatment, for example, than many other client groups.

Hispanic Americans are particularly wed to their community or barrio and have a strong sense of territoriality. Treatment facilities far removed from the sheltered, extended family and community life of the Hispanic person will discourage participation by the alcohol abuser. Finally, the importance of having bilingual and bicultural staff in alcohol treatment programs for Hispanics is suggested. It is widely believed that treatment of Hispanics is more effective when conducted by people of their own ethnicity.

Asian/Pacific Americans

NEEDS ASSESSMENT

In general, alcohol consumption is low and the related number of problems are few among Asian/Pacific Americans. Physiological aversion to alcohol and cultural taboos and community sanctions against excessive alcohol consumption are the primary reasons put forth to explain the relative absence of alcohol abuse in this population group as a whole. There are approximately 20 nationalities covered by the term Asian/Pacific American, however, including Chinese, Japanese, Hawaiians, Samoans, Koreans, Cambodians, Thais, Vietnamese, and Filipinos. Within this varied population, there are numerous drinking practices governed by tradition, community values, acculturation, and degree of utilization of community resources for problem solving.

As more and more Oriental families are assimilated into American culture, it is anticipated by some that there will be more separation from some of the familial traditions, perhaps resulting in more drinking. In addition, different pressures to mix business with social activities can place a stronger emphasis to include alcohol in these activities. It remains to be seen whether a rise in alcohol consumption and of alcohol-related problems for Asian/Pacific Americans occurs as acculturation takes place. To date, it appears that this population group does not present many alcohol-related problems to American society, although some contend that alcohol problems do exist in the community, but go undetected.

OUTREACH

The effects of urbanization, role changes in the family, cultural conflict, economic mobility, and acculturation are closely associated with increased alcohol consumption and alcohol problems. Established drinking patterns and low rates of alcohol problems of many Asian groups may be impacted as these effects become evident. Exposure to advertising and the need for prestige have already affected the patterns of alcohol use among Asian American businesspeople and professionals. Because the evidence indicates that few Asian Americans use existing alcoholism treatment services, educational programs are suggested prior to the development of direct services. Education and information programs using ethnic models, examples, and speakers have proved effective in reaching Asian Americans who previously had not used various social services. Such educational programs should recognize that many Asian Americans do not recognize alcohol as a problem except when it occurs in their own family. Then there is a tendency to deny the prob-

lem or to hide it within the nuclear or extended family. When assistance is sought, Asian Americans may frequently turn to family doctors or ministers. These individuals can also be primary targets of outreach and educational efforts about alcoholism and alcoholism services. Lack of awarenesss of treatment facilities is also a barrier to treatment within this population. Outreach to Asian Americans concerning the location, nature, and benefits of programs is suggested.

TREATMENT CONSIDERATIONS

The role of the Asian/Pacific American family in controlling and taking responsibility for problems and feelings of shame and embarassment concerning alcohol abuse problems suggests that family member involvement may be both positive and negative in the delivery of treatment services. Preparatory work with family members should be encouraged to avoid stigmatization and moralizing. In addition, psychological and counseling services are still at the beginning stages in many Asian countries, and use of these treatment approaches may be received with skepticism.

Cultural and language barriers can limit the use of existing services as well. Asian Americans, particularly the Japanese, may prefer to receive treatment from an ethnic agency. Absence of the development of an initial relationship and alliance between treatment staff and clients reported by existing treatment programs suggests that there needs to be an understanding of the Asian culture, family dynamics, expectations of treatment, and language limitations. AA groups composed of Asian Americans are just beginning to be formed; and this important resource network can be a significant support system for the Asian American who may face stigma and loss of family and community support in the effort to overcome alcohol abuse.

Women

NEEDS ASSESSMENT

Conservative estimates of the number of adult women with alcohol-related problems range from 1.5 million to 2.25 million. Although information regarding drinking among minority women is limited, some factors do emerge. There is a higher percentage of abstainers among black women than among white women, and of those black women who do drink, there is a higher percentage of heavier drinkers. Analysis of alcohol use among Hispanic women indicates that they are more likely to abstain from alcohol than either white or black women. There is reason to believe, however, that significant numbers of Hispanic women who do drink may be experiencing alcohol problems. Alcoholism is a serious problem among American Indian women. The extent of problem drinking by Asian women, while unknown, is probably small since Asians as a group drink relatively little. Finally, studies indicate that homosexual women experience a much higher rate of alcohol problems than heterosexual women.

The lingering stigma of alcoholism for women and reluctance of family, physicians, employers, and others to encourage women to seek treatment are constraints in obtaining a full picture concerning women's alcohol abuse. Nevertheless, you can utilize a variety of needs assessment tools. Advisory committees of community service providers, including informed women in the community, are good sources of information about alcohol problems. Voluntary agencies and national or local women's organizations can be utilized to identify important data repositories or to conduct community surveys. Court records and social service agencies may also be useful data sources.

OUTREACH

The special characteristics of women's drinking and the often hidden nature of alcohol abuse by women suggests indirect as well as direct approaches for reaching this client group. Indirect approaches can include informing community groups and agency staff about the nature and magnitude of alcohol problems among women. Alliances formed with women's clubs and organizations also play an important role, assisting women in breaking through their denial and providing support during treatment and aftercare. Community groups that have frequent contact with women include Departments of Social Services, Parents Without Partners, senior citizen groups, women's clubs, Welcome Wagon, YWCAs, feminist organizations, lesbian groups, the Red Cross, family violence proj-

ects, displaced homemaker groups, Girl Scout troops, women's task forces, and women's lobbying groups. Getting women to see treatment staff under the auspices of "helping others"—a spouse's drinking, family counseling, or a child's development problem—is another excellent way of identifying a woman with a drinking problem.

Group presentations have been successful and are less threatening than personal presentations. Hearing about alcoholism in a group, women may begin to examine their own drinking behavior and ask for help. Direct approaches are also used effectively. Advertisements and fliers that list the symptoms of alcohol abuse can be distributed to agencies whose services are aimed at women and to hotline services. Radio, television, newspapers, and newsletters can describe symptoms, reduce stigma, explain the magnitude of the problem, and indicate available community resources and services. Other outreach and awareness efforts may target the religious community, the criminal justice system, the health care system, and educational organizations.

Getting the word out to the community is a primary outreach goal. In urban areas, your treatment staff can network with a wide variety of women's groups. Outreach efforts in rural communities may differ. In the absence of a variety of service agencies, you may need to function as a health care center, since it is less threatening and less stigmatizing for a woman to enter a health center than an alcoholism facility, particularly in a small community.

Experienced program planners note that outreach to women must emphasize the total person and comprehensive health care, tapping into familial, economic, legal, housing, and transportation aspects of their lives. The special concerns of women must also be met. For instance, your outreach efforts should include an emphasis on gynecological and obstetrical issues, such as fetal alcohol syndrome. Research underscores that a woman's alcohol misuse threatens the well-being of the developing child. Research findings indicate that many women who drink excessively abstain or greatly reduce the amount consumed while pregnant when told of the danger of fetal alcohol syndrome by their obstetrician. Many women are unaware of the potential dangers of using prescription drugs in addition to and in combination with alcohol. Stressing particular problems associated with women's alcohol abuse will help get women into treatment, serve as topics in the treatment process, and be a focus for aftercare planning.

TREATMENT CONSIDERATIONS

The more common approaches to diagnosis include various forms of assessment based upon self-report, clinical observations, and reports from concerned persons. Special considerations at intake for the female alcohol abuser include the advisability of a careful diagnostic evaluation since many alcoholic women will pre-

viously have been diagnosed as depressed, suicidal, hypochondrical, or manic depressive without a careful evaluation of their drinking behavior. Without an adequate drinking history, such diagnoses may be incomplete or incorrect. The careful inquiry about incest, rape, sexual molestation, and battering of the female alcohol abuser should occur when the woman's progress makes the raising of such issues appropriate. Intake screening also should ascertain any nutritional deficiencies, hypoglycemia, eating disorders, obstetric-gynecological problems, dental problems, or vision impairments. Treatment programs have reported the successful use of the written autobiographical account of drinking and its negative consequences during intake and in the development of the treatment plan. Other valuable information to gather at intake includes sources of financial support, status of any children, housing, past debts and obligations, legal entanglements, and family crises.

Treatments may also need to include help for feelings of depression, anxiety, guilt, and shame since low self-esteem, dependency, and negative feelings within relationships are frequent issues for women based on culturally and societally prescribed roles. Sexuality issues are reported to be of major concern for alcoholic women in treatment as well. Based on clinical observation, the alcoholism literature suggests that husbands of alcoholic women are more likely to leave than are the wives of alcoholic men, thus reducing the potentially supportive resources available to these women during the recovery process. In addition, a high percentage of women in treatment may be polydrug users.

The range of services to be provided to women alcohol abusers can be extensive. These services typically include individual and group therapy, family counseling, concerned persons groups, medical and psychiatric services, child care, parenting, vocational and educational programs, legal aid, and assistance with transportation and housing. Recognizing the need for holistic treatment of female alcohol abusers, your program staff will play an important case management role by linking women with local resources and providers of services crucial to recovery.

Aftercare is particularly critical for women and is an important reinforcement process for gains made in treatment—gains that are likely to conflict with role expectations in the home, community, and employment setting to which she is returning. Four approaches to aftercare are suggested: reinforcing and continuing the progress made in treatment usually accomplished through group meetings on a regular basis; providing support for life management problems and sobriety through such groups as AA and Women for Sobriety, Big Sisters, and others; providng sober social functions; and maintaining contact in the event of crisis.

ADMINISTRATIVE ISSUES

Beyond providing treatment for clients, staff in alcoholism programs treating women provide a variety of services that affect a woman's road to recovery. How your staff conduct themselves, their attitudes, interpersonal skills, and job performance standards frequently serve as role models for clients. This role modeling is considered most effective when clients are able to identify personally with treatment staff. For this reason, you must carefully select staff who are representative of the client population.

Subgroups of women within the community, i.e., Black, Hispanic, lesbian, American Indian, and so forth, will create staffing requirements. Of course, key staff in women's alcoholism treatment programs should be women.

There are a number of other considerations in planning women's alcoholism treatment programs that deserve highlighting. Program hours should remain flexible to be accessible for working women. The cost of treatment is a growing barrier for many people. Clearly, women as a group find themselves in a vulnerable financial position. An affordable sliding fee scale can remove a significant barrier for women. Lack of child care creates an additional barrier to some women seeking treatment. Many treatment programs make arrangements for child care components or services. Finally, transportation should be considered in your treatment program design. Women are less likely to have independent transportation and less money to pay for it.

Appendix

Appendix A: Further Readings

Inclusion in this listing does not necessarily imply endorsement of the contents of these materials by the National Institute of Alcohol Abuse and Alcoholism (NIAAA), nor is this list to be regarded as exhaustive. The materials listed were used in the development of this guide; however, a great many other materials relevant to program planning and development can be found in university and public libraries.

PLANNING AND PROGRAM DEVELOPMENT: GENERAL RESOURCES

The following materials cover a broad range of the issues that you must consider in developing a new alcoholism treatment program or expanding an existing program.

Program Standards for Alcoholism Treatment. National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland, 1982. Available from National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. Request NTIS No. PB83-69268, $14.50 paper copy, $4.50 microfiche. This manual sets forth performance criteria for alcoholism treatment programs. The standards cover four broad areas: client-oriented activities; program management and planning; State and local organization and liaison; and program and fiscal accountability. The standards address the specific program characteristics and activities considered necessary for effective operation, based on the views of alcoholism treatment specialists and program administrators as well as national professional organizations in the field.

Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities Serving the Mentally Retarded/Developmentally Disabled. Joint Commission on Accreditation of Hospitals, Chicago, 1985. Available at a cost of $35 from JCAH, 875 North Michigan Avenue, Chicago, IL 60611, Attention Cashier. Request Catologue No. PF 314 (advance payment required; no telephone orders accepted). This manual outlines standards applicable to inpatient, residential, partial-day, and outpatient psychiatric and substance abuse hospitals, facilities, and programs and services for the mentally retarded and developmentally disabled. The standards cover such broad categories as program management, patient management, patient services, and facility management.

A Practical Manual for County Officials on the Treatment of Alcoholism by Jean Hammer, Michael Benjamin, and Gary Jacobs.

National Association of Counties, Washington, D.C., 1977. Available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request PH 89. This booklet discusses the steps necessary to develop alcoholism programs to be funded by the county government. Because it was published in 1977, some of the specific information is now out of date; the process information is generally still applicable, however, particularly as regards needs assessment and fundraising. The information is geared toward developing publicly funded alcoholism treatment programs.

Fifth Special Report to the U.S. Congress on Alcohol and Health. NIAAA, Rockville, Maryland, 1983. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request BK 51.5. This state-of-the-art report includes a chapter of alcoholism treatment that reviews emerging trends in research and practice. It discusses advances in diagnosis and early detection of alcoholism, reviews research on the effectiveness of programs and therapeutic approaches, and outlines future directions for research that will contribute to improved treatment for alcoholics. The report also contains the most current national statistics on the incidence of alcohol problems and alcoholism and the social, economic, and medical consequences of alcoholism—information useful in the needs assessment phase of program planning.

Management Skills for Alcohol Program Administrators. National Center for Alcohol Education, NIAAA, Rockville, Maryland, 1978. Available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request NCAE 009-Trainer Manual; NCAE 010-Participant Workbook (limited quantities). The trainer manual and participant workbook contain information useful to program planners, although the materials are geared to the administrator of an existing program. The training materials were published in 1978, but many of the readings and checklists are still useful. The focus is primarily on developing skills in administrative areas including personnel management, fundraising, and financial management.

Management Program for Alcoholism Services Projects, by John T. Gorby and Associates. NIAAA, Rockville, Maryland, no date. Available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. Request NTIS No. PB85-189116/AS, $22.00 papercopy, $4.50 microfiche. Contains process discussions and readings on planning and evaluation, human resources, organization and management, fundraising, and financial management. The financial management section contains an accounting manual intended to be a "turn-key" accounting system package for alcoholism programs providing outreach, referral, and counseling. Intended for use by programs already in operation, the material is also applicable to many areas of program planning.

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Developing Community Services for Alcoholics: Some Beginning Principles. NIAAA, Rockville, Maryland, 1971. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request PH 57. This brochure was developed more than a decade ago to articulate the principles involved in developing and delivering services to the alcoholic person and family members. Although the treatment field has evolved, the booklet provides a useful philosophical foundation to program planners. The focus is on developing a comprehensive community-based network of services for the alcoholic client, emphasizing interagency cooperation in service delivery.

ADMINISTRATIVE ISSUES

The following documents provide information on one or more specific aspects of treatment program planning or operation.

Classification of Alcoholism Treatment Settings, by R.J. Bast. NIAAA, Rockville, Maryland, 1983. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request PH 200. This document identifies 14 basic settings in which alcoholism treatment services are provided and describes each in terms of type of treatment provided, staffing characteristics, and other distinguishing factors. A glossary is included.

Development of Model Professional Standards for Counselor Credentialing, by Birch & Davis Associates, Inc. NIAAA, Rockville, Maryland, 1984. Available from National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161. Request NTIS No. PB84-245760, $22.00 papercopy, $4.50 microfiche. This report discusses the process and outcome of a nationwide effort to develop model standards for alcoholism and drug abuse counselor credentialing. The document identifies a core set of counselor job tasks and the knowledge and skills essential to competent performance of those tasks. It also provides guidelines for assessing competencies of individuals seeking counselor credentials.

Program Revenue: A Challenge of the Eighties. Fund Raising, Third Party Reimbursement, Client Fees, by Birch & Davis Associates, Inc. National Institute on Drug Abuse, Rockville, Maryland, 1981. Available at a cost of $50 from Birch & Davis Associates, Inc., 8905 Fairview Road, suite 300, Silver Spring, MD 20910. This training guide for program administrators reviews in detail sources of funding and fundraising methods and provides a detailed discussion of third-party reimbursement and client fees. Barriers to generating such revenues are identified, and strategies for overcoming these are provided. In addition, a section on program marketing provides an overview and guidance on how to develop a marketing plan.

Volunteers: Special Focus, Alcohol Health and Research World, Vol. 6, No. 3, 1982. Single copies available free of charge from National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request RPO 383. This magazine issue

includes a range of articles on volunteers in alcoholism programs. Profiles of programs using volunteers are included, as is a listing of further readings.

Procedures for Assessing Alcohol Treatment Needs. Alcohol Epidemiology Data System. NIAAA, Rockville, Maryland, 1983. Available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. Request No. PB83-106856, $34.00 papercopy, $4.50 microfiche. This manual presents a set of procedures for assessing the extent of need for alcoholism treatment services in a community or region. It is intended primarily for use in State or regional alcoholism treatment planning, and details how to estimate the demand for particular types of treatment services based on current utilization of services and on a range of indicators of unmet needs. An abbreviated version of this manual is slated for publication in *Alcohol Health and Research World,* Vol. 9, No. 2, Winter 1984/85. (Single copies available free of charge from NCALI, P.O. Box 2345, Rockville, MD 20852.)

Health Planning Technical Assistance Manual for Alcohol and Drug Abuse Agencies. NIAAA and NIDA, Rockville, Maryland, 1980. Available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request PH 173. This manual is intended to provide State alcoholism agencies with information on how to comply with the National Health Planning and Resources Development Act. The act required that alcohol and drug agencies coordinate with State health planning agencies. The manual contains needs assessment information useful to the program planner, although this is not the primary focus.

Chart of Accounts for Hospitals. American Hospital Publishing, Inc., for the American Hospital Association, Chicago, Illinois, 1976. Available prepaid at a cost of $22.50 from the AHA Services, Inc., P. O. Box 99376, Chicago, IL 60693. Request catalog number 061104. This manual includes a standard chart of accounts, descriptions of an accounting system and proceures, an outline of classifications of expenses, and a chapter on uniform reporting. While it was prepared for use by hospitals, much of the information is transferable to an alcoholsm treatment program. AHPI publishes other materials on financial and administrative management that may be of interest to those planning alcoholism treatment services; a free catalog of publications may be requested from Jo Hohman, Promotion Manager, American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL 60611.

SPECIAL POPULATIONS

Alcohol Topics In Brief. NIAAA, Rockville, Maryland. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request reprints by number. "In Briefs" are three- to four-page summary articles highlighting prevalence, prevention, and treatment information on a wide variety of alcohol-related topics. Each "In Brief" includes a

list of references and is periodically updated by staff of NIAAA's National Clearinghouse for Alcohol Information. Topics of "In Briefs" include the following:

Alcohol and Blacks - RPO 300
Alcohol and American Indians - RPO 307
Alcohol and Youth - RPO 067
Alcohol and Hispanics - RPO 253
Alcohol and the Elderly - RPO 254
Women and Alcohol - RPO 276

Approaches to Treatment of Alcoholism Across Cultural Boundaries, by Joseph Westermeyer and Dale Walker. *Psychiatric Annals* 12(4):434-439, 1982. Available from public and medical school libraries. This article discusses some of the issues to be considered when working across cultural boundaries. Self-assessment, clinical skills, and the planning of services are topics addressed. References and a bibliography are included.

Special Population Issues. Alcohol and Health Monograph No. 4. NIAAA, Rockville, Maryland, 1982. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request BK 105. *Special Population Issues* is a collection of articles on the prevalence, incidence, and the nature of alcohol-related problems of population groups defined by sex, age, race, and ethnicity. Articles cover women, youth, elderly, American Indians, blacks, and Asian Americans. The monograph provides a base of knowledge regarding special populations, including treatment issues. References are included for each article.

Substance Abuse Treatment and Cultural Diversity, by Connie Smith-Peterson. In: *Substance Abuse: Pharmacologic, Developmental, and Clinical Perspectives*, edited by Gerald Bennett, Christine Vourakis, and Donna S. Woolf, 1982. Available from Wiley & Sons, Inc., New York, NY, or in local libraries. This chapter addresses the frequent omission of cultural variables in the consideration of treatment approaches and prevention strategies. The patterns and specific characteristics of substance abuse and related problems are considered in ethnic populations, including black Americans, American Indians, and Hispanics. While the focus is on alcohol use patterns within a cultural context, anthropologic and sociologic perspectives are considered, with many of these concepts applying to the cultural context of other types of substance use and abuse. Implications for substance abuse treatment are identified.

Treatment Services for Youth: Special Focus, Alcohol Health and Research World, Vol. 7, No. 4, 1983. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request RPO 426. This special focus issue includes a collection of articles about youth and alcohol abuse, treatment barriers, treatment approaches, and aftercare. Eleven alcoholism treatment programs for adolescents, offering a

variety of treatment approaches, are profiled. Program contact information is included with each program description.

Advances in Alcoholism Treatment Services for Women. NIAAA, Rockville, Maryland, 1983. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request BK 112. This document is the product of a conference held in Minneapolis, Minnesota, in 1981 to facilitate the sharing of information about women's treatment needs. Of the 45 NIAAA-funded women's treatment programs, 38 were represented at this conference. For programs yet to be estalished, it contains important information about community planning, treatment planning, staffing needs, and issues specific to women.

Alcoholic Women: They Do Recover, by Margaret Wilmore and Joan Volpe. NIAAA, Rockville, Maryland, 1981. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request PH 201. This manual is the result of meetings of 8 program directors of NIAAA-funded women's alcohol programs. Participants discussed the unique outreach and treatment issues faced in initiating women's alcoholism programs. Summary recommendations for implementing services for women and brief program descriptions are also included.

Counseling the Black Client: Alcohol Use and Abuse in Black America, by Peter Bell and Jimmy Evans. Hazelden Foundation, Center City, Minnesota, 1981. Available at a cost of $3.95 from Hazelden Educational Services, Box 176, Center City, MN 55012. As part of a professional education series, this booklet presents an overview of alcohol use and abuse in black America and discusses counseling guidelines when interacting with black clients. Programming ideas and a reference list are included.

Alcohol and the Elderly: Special Focus, Alcohol Health and Research World, Vol. 8, No. 3, 1984. Singles copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request BL 0045. This magazine issue includes a collection of articles focusing on the elderly. Improvement of treatment services for the elderly alcohol abuser is discussed and 8 program profiles are presented. A list of further readings is also included.

The Multidisabled: Emerging Responses-Special Focus, Alcohol Health and Research World, Vol. 5, No. 2, 1980/81. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request RPO 317. The needs of alcohol abusers with additional disabilities are discussed in this special focus issue. Counseling approaches, network development, intervention, treatment, and program models are topics of articles. In addition, articles focus on the needs of blind, deaf, epileptic, spinal cord injured, developmentally disabled,

and mentally retarded substance abusers. A resource list references additional publications as well as groups and organizations providing technical assistance and information.

Resource List for Information on Alcohol and the Handicapped. NIAAA, Rockville, Maryland, no date. Single copies available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Request MS 217. This list cites mateials available on the alcohol-related issues of the multidisabled. Articles cover the deaf, blind, epileptic, and spinal cord injured populations.

Appendix B: Organizations and Information Resources

The following organizations and clearinghouses can provide information and, in some cases, technical assistance to persons planning alcoholism treatment programs. The primary resource for alcoholism treatment program planners remains the State alcoholism agency.

PROFESSIONAL ORGANIZATIONS AND AGENCIES

National Association of State Alcohol and Drug Abuse Directors
444 North Capitol Street, NW
Suite 530
Washington, DC 20001

This professional association can direct those interested in planning alcoholism treatment programs to the appropriate individual in their State; however, the association does not offer direct technical assistance or information to program planners other than to those in State offices. A newsletter for members and other interested persons, *Alcohol and Drug Abuse Report*, is published twice per month. The subscription price is $55 per year.

National Association of Alcoholism Treatment Programs
2082 Michaelson Drive
Suite 212
Irvine, CA 92715

This association represents 360 private sector alcoholism treatment programs; it functions as a trade association for private sector programs and is involved in lobbying as well as provides educational and consulting services to members. The association employs a national health care consultant who is available, for a fee, to work with both members and nonmembers in developing new programs and refining operating programs.

Alcohol and Drug Problems Association
444 North Capitol Street, NW
Suite 181
Washington, DC 20001

This national professional association sponsors conferences and educational seminars for members; recent regional seminars have focused on topics related to alcoholism and drug treatment program management. The

association offers no specialized technical assistance, but will provide information on upcoming seminars and conferences.

National Council on Alcoholism
12 West 21st Street, 7th Floor
New York, NY 10010

This national voluntary organization has affiliates in most areas of the country. NCA is not involved in alcoholism treatment, but rather focuses on educating the public about the nature of alcoholism and providing information and referral services to alcoholics and their families. However, some local affiliates are involved in the treatment area and may be able to provide assistance to program planners. The national office puts out a number of publications for the general public and professionals, covering a range of topics. A free copy of the *Catalog of Publications* may be requested from the national office.

Indian Health Service
Office on Alcoholism
Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

This agency currently funds a number of alcoholism treatment programs serving American Indian tribes. Funding for new programs is not available except in the case of a program designed to serve members of a tribe that has no access to such services and has identified a need for alcoholism treatment services in its Tribal Health Plan. Information and technical assistance can be requested from the regional IHS offices; a listing of these offices may be requested from the national IHS address.

Administration for Native Americans
Office of Human Development Services/DHHS
U.S. Department of Health and Human Services
300 Independence Avenue, SW
Room 5300
Washington, DC 20201

This agency administers the Native Americans Program Act of 1974 and provides funds to federally recognized, off-reservation Indian organizations for the promotion of economic and social development strategies. Applications for grants may include establishing Indian child welfare services, services to Indian elderly, and demonstrations for alcohol-related services that impact the social services delivery system.

Association of Labor Management Administrators and Consultants on Alcoholism
1800 North Kent Street
Suite 907
Arlington, VA 22209

This professional association provides information and educational services to members who are involved in occupational alcoholism or employee assistance programs. While their materials focus on developing early intervention programs in the worksetting, alcoholism treatment planners may find some of their publications of interest. It has 60 local chapters that are often the focus of local occupational alcoholism activity.

Alcoholics Anonymous
Box 459
Grand Central Station
New York, NY 10613

This self-help organization publishes a great many materials useful to those providing alcoholism services as well as to AA members. Nothing specific to program planning is included among their materials, although there are publications directed to counselors. A free listing of publications may be requested.

U.S. Department of Transportation
National Highway Traffic Safety Administration
Office of Alcohol Countermeasures
NTS - 20
400 Seventh Street, SW
Room 5130
Washington, DC 20590

The National Highway Traffic Safety Administration is an agency within the U.S. Department of Transportation. The Office of Alcohol Countermeasures provides overall program management and evaluation assistance and guidance in all countermeasures that deal with the drinking and driving problem. Reports and publications are available on a wide range of topics.

INFORMATION RESOURCES: ALCOHOL SPECIFIC

National Clearinghouse for Alcohol Information
P. O. Box 2345
Rockville, MD 20852

The National Institute on Alcohol Abuse and Alcoholism information clearinghouse maintains an automated database and an inventory of publications on alcohol-related topics. Free database searches may be requested. In addition, a number of publications of interest to alcoholism treatment

programs planners are available (see Appendix A). Requests for a search should indicate the topic areas you are interested in and the use you intend to make of the information; include your telephone number in case reference analysts need to contact you to clarify your request.

National Institute on Drug Abuse Clearinghouse
Room 10A-52
5600 Fishers Lane
Rockville, MD 20857

A library collection, database, and publications are available from this Federal clearinghouse. The clearinghouse has publications on topics related both to drug and alcohol abuse; a free publications listing may be requested.

National Institute on Mental Health (NIMH) Public Inquiries
Room 15C-17
5600 Fishers Lane
Rockville, MD 20857

This information center distributes publications and pamphlets on NIMH research, activities, and programs, as well as a broad spectrum of mental health topics for mental health administrators and for the general public. A free publications listing may be requested.

Wisconsin Clearinghouse
1954 East Washington Avenue
Madison, WI 53704

This official information and materials clearinghouse for the State of Wisconsin develops publications in the areas of mental health, alcohol and other drugs, youth development and health promotion. The focus of the materials is primarily on prevention; however, manuals for professionals include a guide for group facilitators, an alternative funding resources manual, and resource guides on various special populations. A catalog of publications may be requested free of charge; there is a fee for copies of publications.

Johnson Institute
510 First Avenue North
Minneapolis, MN 55403

This independent nonprofit organization offers information, consultation services, training workshops, films, and publications for those who operate alcoholism and drug abuse treatment programs or who are interested in moving into this arena. The institute will send free copies of its catalog and descriptive brochures. Feasibility assessment and program development consultation is provided to those starting alcoholism treatment programs. Fees depend on the

extent of services individually needed. Further information is available from the Specialized Services Department, (612) 341-0435.

Hazelden Educational Materials
P.O. Box 176
Center City, MN 55012

This nonprofit private institution provides publications and films for a fee. Materials focus on issues relevant to the recovering alcoholic, to friends and family members, and to professional caregivers. A free copy of the organization's catalog may be requested.

INFORMATION RESOURCES: GENERAL HEALTHCARE PLANNING

Project SHARE
P.O. Box 2309
Rockville, MD 20852

This Federal information clearinghouse provides reference and referral services designed to improve the management of human services; an automated database on topics related to human services program development and management is maintained. Planners may request searches of the database, or may request a listing of already prepared bibliographies and monographs. There is a fee for all materials and services provided by Project SHARE. It is important to include your telephone number with your request so reference specialists can call to discuss what your information needs are and the costs. The collection is not alcohol specific.

National Library of Medicine
8600 Rockville Pike
Bethesda, MD 20209

The library maintains a number of automated databases, containing citations and abstracts of the most recent literature on a variety of topics; of particular interest to alcoholism treatment program planners is the Health Planning and Administration database (HEALTH PLANNING ADMIN). In most areas of the country, public libraries or university libraries can assist planners in obtaining a search of this database for a fee. The literature included in the database is not alcohol specific, but covers a broad range of topics related to planning health care services.

National Health Information Clearinghouse
P.O. Box 1133
Washington, DC 20013

This federally funded clearinghouse is intended to help requestors locate health information by referring them to the appropriate resources; publications are also available. The

clearinghouse can provide planners with direction in locating organizations or agencies that might be of assistance.

National Health Planning Information Center
Parklawn Building
Room 9A-20
Rockville, MD 20857

This information center is intended to provide health planners and agencies administering healthcare programs with reference searches and referrals. The center produces a number of publications, including an abstract bulletin, monographs, and bibliographies. The information is not alcohol specific, but covers the range of issues involved in planning healthcare services.

Appendix C: State and Territorial Alcoholism Program Directors

ALABAMA	Department of Mental Health Ken Wallis, Acting Commissioner 200 Interstate Park Drive P.O. Box 3710 Montgomery, AL 36193 (205) 271-9209
ALASKA	Department of Health and Social Services Office of Alcoholism and Drug Abuse Matthew Felix, Coordinator Pouch H-05F, 114 Second Street Juneau, AK 99811 (907) 586-6201
ARIZONA	Arizona Department of Health Services Alcohol Abuse and Alcoholism Section Gwen G. Smith, Program Representative Office of Community Behavioral Health 1740 W. Adams, Room 001 Phoenix, AZ 85007 (602) 255-1152
ARKANSAS	Arkansas Office on Alcohol and Drug Abuse Prevention Paul T. Behnke, Director 1515 W. 7th Avenue, Suite 310 Little Rock, AR 72202 (501) 371-2603
CALIFORNIA	Department of Alcohol and Drug Programs Chauncey Veatch III, Esq., Director 111 Capitol Mall, Suite 450 Sacramento, CA 95814 (916) 445-1940
COLORADO	Alcohol and Drug Abuse Division Robert B. Aukerman, Director 4210 East 11th Avenue Denver, CO 80220 (303) 320-6137
CONNECTICUT	Connecticut Alcohol and Drug Abuse Commission Donald J. McConnell, Executive Director 999 Asylum Avenue, 3rd Floor Hartford, CT 06105 (203) 566-4145
DELAWARE	Division of Alcoholism, Drug Abuse and Mental Health Bureau of Alcoholism and Drug Abuse Sally Allhouse, Chief 1901 North Dupont Highway New Castle, DE 19720 (302) 421-6101

DISTRICT OF COLUMBIA	Office of Health Planning and Development Simon Holliday, Chief 1875 Connecticut Ave., N.W. Suite 836 Washington, DC 20009 (202) 673-7481
FLORIDA	Alcoholic Rehabilitation Program Department of Health and Rehabilitation Services Thomas Holt, Supervisor 1317 Winewood Boulevard, Room 148A Tallahassee, FL 32301 (904) 488-0900
GEORGIA	Division of Mental Health, Mental Retardation and Substance Abuse Georgia Department of Human Resources Lee Martus, Acting Director 878 Peachtree St., N.E., 3rd Floor Atlanta, GA 30309 (404) 894-4785
GUAM	Territory of Guam Mental Health and Substance Abuse Agency Dr. David L.G. Shimizu, Interim Director P.O. Box 8896 Tamuning, Guam 96911 011-671-477-9704/5
HAWAII	Department of Health Alcohol and Drug Abuse Branch Joyce Ingram-Chinn, Branch Chief P.O. Box 3378 Honolulu, HI 96813 (808) 548-4280
IDAHO	Bureau of Substance Abuse Department of Health and Welfare Charles E. Burns, Director 450 West State Street, 4th Floor Boise, ID 83720 (208) 334-4368
ILLINOIS	Department of Alcohol and Substance Abuse Dan Behnke, Acting Director 300 N. State St., Suite 1500 Chicago, IL 60610 (312) 822-9860
INDIANA	Division of Addiction Services Department of Mental Health Joseph E. Mills, III, Director 429 North Pennsylvania Indianapolis, IN 46204 (317) 232-7816
IOWA	Department of Substance Abuse Mary L. Ellis, Director 505 Fifth Avenue Suite 202 Des Moines, IA 50319 (515) 281-3641
KANSAS	Alcohol and Drug Abuse Services James A. McHenry, Jr., Ph.D. Commissioner 2700 West Sixth Street, 2nd Floor Biddle Building Topeka, KS 66606 (913) 296-3925
KENTUCKY	Cabinet for Human Resources Michael Townsend, Director Division of Substance Abuse Department for Mental Health and Mental Retardation

275 East Main Street
Frankfort, KY 40621 (502) 564-2880

LOUISIANA
Office of Prevention and Recovery from Alcohol and Drug Abuse
Burn Ridgeway, Assistant Secretary
P.O. Box 4049
655 North 5th Street
Baton Rouge, LA 70801 (504) 342-2488

MAINE
Office of Alcoholism and Drug Abuse Prevention
Neill Miner, Director
State House Station ÷ 11
Augusta, ME 04333 (207) 289-2781

MARYLAND
Alcoholism Control Administration
John Bland, Director
201 West Preston Street, 4th Floor
Baltimore, MD 21201 (301) 383-2781

MASSACHUSETTS
Division of Alcoholism
Edward Blacker, Ph.D., Director
150 Tremont Street
Boston, MA 02111 (617) 727-1960

MICHIGAN
Office of Substance Abuse Services
Robert Brook, Administrator
3500 North Logan Street
P.O. Box 30035 Lansing, MI 48909 (517) 373-8603

MINNESOTA
Chemical Dependency Program Division
Cynthia Turnure, Executive Director
Department of Human Services
Space Center
444 Lafayette Road
St. Paul, MN 55101 (612) 296-3991

MISSISSIPPI
Division of Alcohol and Drug Abuse
Ann D. Robertson, M.S.W., Director
1102 Robert E. Lee Office Building
Jackson, MS 39201 (601) 359-1297

MISSOURI
Division of Alcoholism and Drug Abuse
R.B. Wilson, Director
2002 Missouri Boulevard
P.O. Box 687
Jefferson City, MO 65101 (314) 751-4942

MONTANA
Alcohol and Drug Abuse Division
Department of Institutions
Robert Anderson, Administrator
1539 - Eleventh Avenue
Helena, MT 59620 (406) 444-2827

NEBRASKA
Division on Alcoholism and Drug Abuse
Cecilia Willis, Director
P.O. Box 94728
Lincoln, NE 68509 (402) 471-2851 x 415

NEVADA
Bureau of Alcohol and Drug Abuse
Department of Human Resources
Richard Ham, Chief

	505 East King Street Carson City, NV 89710 (702) 885-4790
NEW HAMPSHIRE	Office of Alcohol and Drug Abuse Prevention Geraldine Sylvester, Director Health and Welfare Building Hazen Drive Concord, NH 03301 (603) 271-4627
NEW JERSEY	Division of Alcoholism New Jersey Department of Health Riley Regan, Director 129 East Hanover Street Trenton, NJ 08608 (609) 292-8947
NEW MEXICO	Alcoholism Bureau Joe Gallegos, Acting Chief Behavioral Health Services Division Crown Building P.O. Box 968 Santa Fe, NM 87504-0968 (505) 984-0020, x493
NEW YORK	New York Division of Alcoholism and Alcohol Abuse Robert V. Shear, Director 194 Washington Avenue Albany, NY 12210 (518) 474-5417
NORTH CAROLINA	Division of Mental Health, Mental Retardation and Substance Abuse Services Alcohol and Drug Abuse Section Steven L. Hicks, Deputy Director 325 North Salisbury Street Raleigh, NC 27611 (919) 733-4670
NORTH DAKOTA	State Department of Human Services Division of Alcoholism and Drug Abuse Tom R. Hedin, Director State Capitol Bismarck, ND 58505 (701) 224-2769
NORTHERN MARIANA ISLANDS	Dr. Torres Hospital Ben Kaipat, Medical Officer Saipan, Mariana Islands 96950 6112, 6222 (through International Operator 0-160691)
OHIO	Ohio Department of Health Bureau of Alcohol Abuse and Alcoholism Recovery Wayne Lindstrom, Chief 170 North High Street Columbus, OH 43215 (614) 466-3445
OKLAHOMA	Alcohol and Drug Abuse Division Thomas Stanitis, M.A., M.H.S., Deputy Commissioner P.O. Box 53277, Capitol Station Oklahoma City, OK 73152 (405) 521-0044

OREGON	Mental Health Division Programs for Alcohol and Drug Problems Jeffrey N. Kushner Assistant Administrator 2575 Bittern Street, N.E. Salem, OR 97310 (503) 378-2163
PENNSYLVANIA	Office of Drug and Alcohol Problems Lucille Fleming, Deputy Secretary for Drug and Alcohol Programs P.O. Box 90, Department of Health Health and Welfare Building, Room 809 Harrisburg, PA 17120 (717) 787-9857
PUERTO RICO	Puerto Rico Department of Addiction Control Services Sonia Puig Sayas Assistant Secretary for Alcoholism Box Piedras, PR 00928 (809) 763-5014 or 763-7575
RHODE ISLAND	Department of Mental Health, Mental Retardation and Hospitals Division of Substance Abuse William Pimental, Assistance Director Substance Abuse Administration Building Cranston, RI 02920 (401) 464-2091
AMERICAN SAMOA	Human Services Clinic Alcohol and Drug Program Fualaau Hanipale, Director LBJ Tropical Medical Center Pago, Pago, American Samoa 96799 011-684-633-5139
SOUTH CAROLINA	South Carolina Commission on Alcohol and Drug Abuse William J. McCord, Director 3700 Forest Drive Suite 300 Columbia, SC 29204 (803) 758-2521
SOUTH DAKOTA	Division of Alcohol and Drug Abuse Lois Olson, Director Joe Foss Building 523 East Capitol Pierre, SD 57501 (605) 773-3123
TENNESSEE	Tennessee Department of Mental Health and Mental Retardation Robert Currie, Assistant Commissioner Alcohol and Drug Abuse Services James K. Polk Building 505 Deaderick Street Nashville, TN 37219 (615) 741-1921
TEXAS	Texas Commission on Alcoholism Ross Newby, Executive Director 1705 Guadalupe Street Austin, TX 78701 (512) 475-2577

TRUST TERRITORY OF THE PACIFIC ISLANDS	Masao Kumangai, M.D., Director Health Services Office of the High Commissioner Saipan, Mariana Islands 96950 Trust Territory of the Pacific Islands 9854, 9355 (through International Operator 0-160691)
UTAH	Division of Alcoholism and Drugs F. Leon PoVey, Director 150 West North Temple, Room 350 P.O. Box 45500 Salt Lake City, UT 84145 (801) 533-6532
VERMONT	Alcohol and Drug Abuse Division Richard Powell II, Director 103 South Main Streeet Osgood Building Waterbury Complex Waterbury, VT 05676 (802) 241-2170
VIRGINIA	Division of Substance Abuse Wayne Thacker, Director Office of Substance Abuse P.O. Box 1797 203 Governor Street Richmond, VA 23214 (804) 786-5313
VIRGIN ISLANDS	Division of Mental Health Alcoholism and Drug Dependency Patricia Todman, Ph.D., Director P.O. Box 7309 St. Thomas, US VI 00801 (809) 774-4888
WASHINGTON	Bureau of Alcohism and Substance Abuse Glen Miller, Director Mailstop, OB-44W Olympia, WA 98504 (206) 753-5866
WEST VIRGINIA	Alcoholism and Drug Abuse Program Division of Behavioral Health Services Jack Clohan, Jr., Director State Capitol 1800 Washington Street East Charleston, WV 25305 (304) 348-2276
WISCONSIN	State Bureau of Alcohol and Other Drug Abuse Larry W. Monson, Director 1 West Wilson Street, Room 441 P.O. Box 7851 Madison, WI 53707 (608) 266-2717
WYOMING	Division of Community Programs Jean DeFratis, Director, Alcohol and Drug Abuse Programs Hathaway Building, 3rd Floor Cheyenne, WY 82002 (307) 777-7115 x 7118